# CHAPTER IV
# COVERED SERVICES AND LIMITATIONS

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## INTRODUCTION

The Commonwealth of Virginia offers the following waivers under the Medical Assistance Program:

- Elderly and Disabled Waiver;
- AIDS Waiver;
- Consumer-Directed Personal Attendant Services (CDPAS) Waiver;
- Technology Assisted Waiver;
- Mental Retardation Waiver; and
- Individual and Family Developmental Disabilities Support Waiver (DD).

These waivers differ according to the populations they target, the medical and functional criteria for eligibility within each waiver category, the pre-admission screening process for each waiver, and the services offered under each waiver. Under no circumstances can a recipient be enrolled in and receive services under more than one waiver during the same time period.

## ELDERLY AND DISABLED WAIVER

The Department of Medical Assistance Services (DMAS) provides reimbursement for the services provided in the Elderly and Disabled (E&D) Waiver, which is designed to offer recipients an alternative to nursing facility placement. These services include personal care, respite care, adult day health care (ADHC) and Personal Emergency Response Systems (PERS). Recipients may be authorized to receive one or more of these services, either solely or in combination, based on the documented need for the service(s) and the recipient's choice of services in order to avoid nursing facility placement. PERS is not a stand-alone service and requires either personal care, or ADHC as the primary service. The Nursing Home Pre-Admission Screening Team (Screening Team) must deem the individual eligible for Elderly and Disabled Waiver services and may provide an initial authorization for services to begin. In addition, WVMI (the DMAS contracted agent to conduct pre-authorization) must preauthorize all waiver services in order for the provider to be reimbursed.

## PROVIDER'S ROLE IN SERVICE DELIVERY-FINANCIAL ELIGIBILITY

Every recipient who receives a Medicaid-funded service must have his or her financial status evaluated by the Department of Social Services (DSS) in the city or county in which he or she resides. This evaluation is completed at the same time the Screening Team completes its evaluation of whether an individual meets waiver criteria. To determine whether an individual received on referral is Medicaid-eligible, the provider may do any of the following: contact the Audio Response System (ARS) line (see Chapter I), view the recipient's Medicaid card, or contact DSS. It is the responsibility of the provider to verify a recipient's eligibility each month in which services are provided.

For questions about financial eligibility criteria or a recipient's financial eligibility status, contact the local DSS eligibility worker. If there is any question about whether the individual meets waiver criteria, the provider is encouraged to contact a Review Analyst in the Community-Based Care (CBC) Review Unit at WVMI prior to admitting the recipient to services.

If a recipient's Medicaid number is pending, the provider may choose to begin providing services, but does so without a guarantee of reimbursement from DMAS should a final Medicaid number not be assigned.

**MEDICAID APPLICATION PENDING**

DMAS cannot reimburse for E&D Waiver services rendered unless:

- The recipient has been assessed and approved for E&D Waiver services through the Nursing Home Pre-Admission Screening process or by WVMI for the addition of a secondary service;
- The recipient is financially Medicaid-eligible on the dates that services are rendered; and
- The recipient has received services that are covered under the E&D Waiver as defined by DMAS.

There may be cases in which the recipient has been assessed and approved for services through the Nursing Home Pre-Admission Screening process, but final financial Medicaid eligibility has not been determined. In these cases, the provider may choose to provide services, as approved by the Nursing Home Pre-Admission Screening Team, while awaiting the final eligibility decision by the local DSS regarding Medicaid financial eligibility.

If the recipient is determined to be financially Medicaid-eligible, the date of Medicaid financial eligibility may be retroactive (i.e., the effective eligibility date established is prior to the date of approval of the Medicaid application). DMAS will reimburse the provider to the retroactive date of eligibility, if all DMAS E&D Waiver regulations and policies have been followed.

**PROVIDER'S RESPONSIBILITY FOR THE PATIENT INFORMATION FORM (DMAS-122)**

The Patient Information form (DMAS-122) is used by the provider and the local DSS to exchange information regarding the responsibility of a Medicaid-eligible recipient to make payment toward the cost of services or other information that may affect the eligibility status of a recipient. The primary provider is responsible for the collection of any patient pay amounts as indicated by DSS on the DMAS-122. (The "Exhibits" section at the end of this chapter contains a sample of the form and the instructions for its completion.) The provider must ensure that a completed DMAS-122 for the current year is in the recipient's

record prior to billing. A new DMAS-122 is generated by the local DSS at least annually or when the recipient's patient pay changes.

The E&D Waiver provider must notify WVMI and the local DSS in writing via the DMAS-122 of the provider's last date of service delivery when any of the following circumstances occurs:

- A recipient dies - Include the date of death.
- A recipient is discharged or terminated from services - The date of discharge or termination should be the last date services were rendered for that recipient. This also includes circumstances when the recipient is discharged from one E&D Waiver provider and is admitted to another E&D Waiver provider.
- Any other circumstances (including hospitalization) which cause services to cease or become interrupted for more than thirty (30) days.

EXAMPLE: The provider delivered services to a recipient through the third of a given month, then the recipient was hospitalized and died on the fifteenth. Even though the provider kept the case open to see if the recipient would need services post-hospitalization, the date submitted on the DMAS-122 would be the third since this was the provider's last date of service delivery.

It is the responsibility of the provider to assure that a DMAS-122 for the current year is in the record prior to billing.

When combined services are received, the personal/respite care provider must send the ADHC center a DMAS-122 when any of the above circumstances occur. The DMAS-122 must include the personal/respite care provider's last date of services. Also, the ADHC center should notify (via the DMAS-122) the personal/respite care provider if any of the above circumstances occur.

Uses of the DMAS-122 include the following:

- Personal/Respite Care/ADHC Service Initiation

  As soon as the provider initiates services, it must send a Patient Information form (DMAS-122) to the eligibility unit of the appropriate local Department of Social Services indicating the provider's first date of service delivery.

  It is advisable for the provider to contact the eligibility worker prior to the start of services for assurance of the recipient's Medicaid eligibility. After being notified of the begin date of service, the eligibility worker will return the same DMAS-122 to the provider with the bottom section completed, showing confirmation of the recipient's Medicaid identification number, the recipient's patient pay amount, and the date on which the recipient's Medicaid eligibility was effective. A copy of this completed DMAS-122 must be maintained in the recipient's file.

The personal/respite care provider is responsible for completing the DMAS-122 and deducting the patient pay amount from their billing. If the recipient is not receiving personal/respite care services, the ADHC provider must do this.

- Patient Pay Amount
    - Each Medicaid recipient of home and community-based care is allowed to keep a portion of his or her income to meet his or her own maintenance needs. This maintenance allowance is higher for the individual staying at home and receiving community-based care than for the individual in a nursing facility. The maintenance allowance for recipients of the E&D Waiver is equal to 100% of the current Supplemental Security Income (SSI) individual payment standard.
    - The maintenance allowance and any other allowable deduction (e.g., medical insurance payments) are deducted from the individual's income to arrive at that individual's patient pay amount. The patient pay for home and community-based care from a SSI recipient will always be $0.

**CHANGE OF RESIDENCE**

If a recipient's residence changes, the provider must record this in the recipient's record and notify the local DSS. This notification must be immediate and in writing.

**PATIENTS WITH COMMUNICABLE DISEASES**

Current information regarding the transmission of Acquired Immune Deficiency Syndrome (AIDS) and other similar communicable diseases indicates that these diseases are not transmitted through casual contact, and isolation techniques or procedures are not required for providing care to recipients in their homes.

However, certain routine hygienic precautions, designed to prevent the spread of all communicable diseases, including bloodborne infections, should be taken by all providers when rendering care to any recipient, regardless of his or her known medical illness. These precautions should include care in handling sharp objects such as needles, the wearing of disposable gloves when one could become exposed to blood or other body fluids, and scrupulous hand washing before and after caring for each recipient.

Providers are prohibited from discriminating against recipients who have been diagnosed as having AIDS and other communicable diseases. Virginia offers a range of home and community-based care services, which include personal/respite care through an approved waiver for recipients with AIDS/HIV, the AIDS Waiver.

The determination of the appropriateness and authorization for E&D Waiver services will not be made solely on diagnosis. The Screening Team will consider the appropriateness of these services based upon the stage of the disease process. Any questions regarding this

policy should be directed to the review analyst at WVMI by phoning (804) 648-3159 or 1-800-299-9864.

## HOSPITALIZATION OF RECIPIENTS

When a recipient is hospitalized, the provider should contact the hospital discharge planner or hospital Social Services department to facilitate discharge planning. If the recipient will not be returning to the home with E&D Waiver services, the provider is instructed to terminate services and send a DMAS-122 to the local DSS and to WVMI which indicates the recipient's last date of service. The E&D Waiver services provider must determine whether the recipient received inpatient rehabilitation services while in the hospital. If this was the case, even for only a day, a new Pre-Admission Screening is required before the recipient can be readmitted to waiver services, regardless of the length of stay.

If the recipient or family member requests an increase in hours following a hospitalization, the nurse must make a post-hospitalization visit to the recipient's home and assess the need for the increase. WVMI will not approve an increase in hours prior to the recipient's discharge from the hospital and the nurse's in-home post hospital assessment.

## RECIPIENTS WITH MENTAL RETARDATION APPROVED FOR SERVICES

Federal waiver programs are designed to serve a specific targeted population. The E&D Waiver can only serve recipients who are at risk of nursing facility placement. The majority of recipients with a diagnosis of mental retardation have active treatment needs that could not be met in a nursing facility. These recipients would be at risk of placement in an intermediate care facility for the mentally retarded (ICF/MR) rather than a nursing facility. Before any recipient with a diagnosis of Mental Retardation (MR) can receive services under the E&D Waiver, the recipient must be assessed by the local Community Services Board (CSB) to determine whether active treatment needs exist. This assessment is done on the DMAS-101B. Recipients with a Mental Illness/Mental Retardation (MI/MR) diagnosis must have a DMAS-101A completed by the Nursing Home Pre-Admission Screening Team and a referral made to the CSB for a DMAS-101B. The CSB evaluation and DMAS-101B must be completed prior to the Nursing Home Pre-Admission Screening Teams' authorizing any services on the DMAS-96.

WVMI will review the assessments of all recipients with MR who are approved for the E&D Waiver to determine the appropriateness of E&D Waiver services. Recipients eligible for the E&D Waiver will typically be those who are too ill to attend outside training. E&D Waiver services should not open to services any recipient with a MR diagnosis until the assessment has been reviewed and deemed appropriate for services by WVMI. The provider must have a completed DMAS-101A and DMAS-101B on any individual with mental retardation that is being served under the E&D Waiver.

## RECIPIENTS WITH MENTAL ILLNESS APPROVED FOR SERVICES

Recipients with Mental Illness (MI) must have a DMAS 101A completed by the NHPAS Team and a referral made to be evaluated by the CSB to determine whether their primary need is for active treatment of their mental illness. Active treatment is defined as an aggressive program of specialized services geared toward "providing the recipient with as much self determination and independence as possible and the prevention or deceleration of regression or loss of current optimal functional status." If the recipient's primary need is for treatment of mental illness, the recipient would be at risk of placement in an Institution for the treatment of Mental Disease (IMD) or a psychiatric hospital, rather than a nursing facility. Such recipients are not appropriate for the E&D Waiver. Only those who have medical or nursing needs that require the level of care of a nursing facility are eligible to receive the E&D Waiver services. The CSB will complete an assessment of active treatment needs of recipients diagnosed with mental illness on the DMAS-101B.

## SUSPECTED ABUSE OR NEGLECT

If the provider knows or suspects that an E&D Waiver recipient is being abused, neglected, or exploited, Virginia law (§§ 63.1-55.3 and 63.1-55.4, Code of Virginia) mandates that the party having knowledge or suspicion of the abuse, neglect, and/or exploitation, report this to the local DSS. DSS (Adult Protective Services) is responsible for the investigation of alleged abuse, neglect, and exploitation.

The contact with the DSS may be made anonymously, but the personal/respite/ADHC record must note the alleged abuse, neglect or exploitation and state that the appropriate report has been made.

## ASSESSMENT AND AUTHORIZATION PROCEDURES FOR ELDERLY AND DISABLED WAIVER SERVICES

Elderly and Disabled Waiver services will be offered only to recipients who have been determined eligible for E&D Waiver services by a Nursing Home Pre-Admission Screening Team and authorized by WVMI, and for whom an appropriate and cost-effective plan of care can be developed. The Screening Team must have explored the medical, social, and nursing needs of the recipient, analyzed the specific service needs of the recipient, and evaluated whether a service or combination of existing services is available to meet these needs. The Screening Team must have explored alternative settings and services, to provide the required care before making the referral for the E&D Waiver services. (See Exhibits at the end of this chapter for a copy of the nursing facility criteria.)

Federal regulations governing Medicaid coverage of home and community-based services under an approved waiver specify that services provided under waiver authority must be targeted to recipients who have a need for the level of care provided in an alternative institutional placement when there is a reasonable indication that a recipient might need the services in the near future (that is, a month or less) unless he or she receives home or community-based services. Under the E&D Waiver, services may be furnished only to recipients:

1. who meet the nursing facility criteria as outlined in the "Exhibits;"
2. who are financially eligible for Medicaid;
3. for whom an appropriate cost-effective plan of care can be established;
4. who are not residents of nursing facilities (licensed by the Virginia Department of Health), assisted living facilities (licensed by DSS), or adult foster homes (approved by local departments of social services);
5. when there are no other or insufficient community resources to meet the recipients' needs; and
6. whose health, safety, and welfare (HSW) in the home environment can be ensured.

To ensure that Virginia's E&D Waiver is offered only to recipients who would otherwise be placed in a nursing facility, E&D Waiver services can be considered only for recipients who meet the functional requirements and medical nursing need for nursing facility placement. E&D Waiver services must be the critical services that enable the recipient to remain at home rather than being placed in a nursing facility.

The Screening Team determines the recipient's need for E&D Waiver services. A request for a pre-admission screening can be initiated by the recipient who desires the requested care, a family member, physician, local health department, or social services professional, or any other concerned individual in the community. The appropriate assessment instrument, the Uniform Assessment Instrument (UAI) must be completed in its entirety.

The Nursing Home Pre-Admission Screening packet consists of the following forms:

- a complete Virginia Uniform Assessment Instrument (UAI-12 pages);
- the Screening Team Authorization (DMAS-96);
- the Screening Team Plan of Care (DMAS-97);
- the DMAS-101A&B (for recipients who have a diagnosis of Mental Illness, Mental Retardation, or a Related Condition);
- documentation of the recipient's choice;
- the DMAS-20 (Consent to Exchange Information); and
- the Screening Team decision letter.

The screening packet must be complete, and the assessment and authorization (DMAS-96) must be approved by the Public Health physician (for recipients in the community) or attending physician (for recipients in the hospital). The Plan of Care (DMAS-97) indicates

the services needed and the individuals who will provide the services. If authorizing ADHC, the Screening Team must indicate on the DMAS-97 the number of days the recipient will be attending and whether transportation services will be required. WVMI review analysts use this information to enter the amount of services into the recipient's file. This is the amount of service for which the provider is authorized to bill DMAS. Increase of days in ADHC attendance must be preauthorized by WVMI.

If authorizing personal/respite care, the Screening Team must indicate on the DMAS-97 the services needed, any special needs of the recipient's environment, and the support available to provide services. The Screening Team will note the number of days per week that care is needed but will not authorize the amount of service each day. Supervision time may be authorized on the DMAS-97. This allows the provider to include supervision in the plan of care, within the Level of Care hours. If supervision will exceed the Level of Care hours, this must be preauthorized by WVMI. The Screening Team Plan of Care also serves as written notification to the recipient of the estimated patient pay responsibility, when this information is available at the time of the screening, and documents the recipient's choice of long-term care options and choice of provider.

If E&D Waiver services are authorized and there is more than one approved provider in the community willing and able to provide care, the recipient must have the option of selecting the provider of his or her choice. WVMI may request to see the right to choose form.

The decision of the Screening Team may be appealed to DMAS. This decision may be appealed in writing by the recipient or his or her legally appointed representative. All appeals must be filed within 30 days of the date of the final decision notification. Appeals should be directed to:

Director, Appeals Division
Department of Medical Assistance Services
600 East Broad Street, Suite 1300
Richmond, Virginia 23219

**FORMS REQUIRED FOR ADMISSION TO ELDERLY AND DISABLED WAIVER SERVICES**

The Screening Team determining recipient eligibility for waiver services will call the provider first to notify the provider that the recipient has chosen the provider for services and to determine if the provider is able to initiate services promptly for the recipient. Providers may accept referrals for services only when staff is available to initiate services within two (2) weeks. If the provider can accept the referral, the Screening Team will send the provider a complete packet required for the provider to admit the recipient to services. A provider should not initiate any services prior to the receipt of the required screening and paperwork.

If the provider does not receive a completed packet of referral forms, as noted below, from the Nursing Home Pre-Admission Screening Team, the provider must notify the responsible Nursing Home Pre-Admission Screening Team and request the completed packet. Accurate and complete packages will help reduce delays in enrollment and delays

in billing. A provider will not be reimbursed for services until WVMI receives the packet of information completed by the Screening Team, along with the provider's plan of care showing the start of care date.

The service authorization date is the date of the physician's signature on the DMAS-96. If the recipient has been receiving personal/respite care services and the provider requests the addition of ADHC, Medicaid will not pay for any ADHC services delivered prior to the authorization date on the WVMI authorization letter. The provider should have a Medicaid identification number for any authorized recipient prior to the start of Medicaid-funded services if the provider wants to guarantee reimbursement for services provided.

The forms which must be completed by the Screening Team and forwarded to the E&D Waiver provider are:

- the original Virginia Uniform Assessment Instrument (UAI);
- the DMAS-101(A or B) (for recipients with mental illness or mental retardation);
- the original of the Nursing Home Pre-Admission Screening Authorization (DMAS-96);
- the original of the Screening Team Plan of Care (DMAS-97); and
- a copy of the DMAS-20, Consent to Exchange Information form.

When the Screening Team authorizes combined services, it will send the original forms to the personal/respite care provider and a copy to the ADHC Center. If the recipient has been screened and approved to receive ADHC and the need for personal/respite care and/or PERS has been identified after ADHC has been initiated, the ADHC or personal/respite care provider must contact a WVMI review analyst for authorization of personal/respite care/PERS. ADHC would then become the secondary program, with regard to the patient pay amount. WVMI will conduct an assessment of the need for the additional Community-Based Care service (personal, respite care, or PERS) and, if appropriate, will authorize the additional service.

The WVMI review analyst will need the following information to complete this authorization:

- The anticipated provider of personal/respite care/PERS services (including the Medicaid provider identification number);
- The anticipated start date for personal/respite care/PERS services; and
- The estimated number of hours and times the personal/respite care/PERS is needed.

When the need for an additional E&D Waiver service has been identified (according to the criteria above), the provider of the initial E&D Waiver service must contact WVMI. WVMI will conduct an assessment of the recipient's primary caregiver's need for respite care and, if appropriate, authorize respite care. It is at the discretion of WVMI's review analyst whether documentation will need to be submitted from the provider. In cases where PERS is the additional service identified, the initial provider should assist the recipient in obtaining this service.

The provider must submit to WVMI a copy of the Admission Package: the Uniform Assessment Instrument (UAI), the Nursing Home Pre-Admission Screening Authorization (DMAS-96), the Screening Team Plan of Care (DMAS-97) or DMAS-300 for Respite Care, the provider Plan of Care (DMAS-97A), the Adult Day Health Care Interdisciplinary Plan of Care (DMAS-301), the DMAS-101 for recipients with mental illness or mental retardation, the Nursing Assessment form which indicates the recipient's level of care (DMAS-99), and the Patient Information Form (DMAS-122) if the DMAS-122 is available at the time of submission of the admission package. The provider will retain the originals.

Providers are responsible for reviewing the recipient's Medicaid card or calling the toll-free eligibility verification number (1-800-884-9730) to confirm the recipient's Medicaid eligibility status prior to the start of care, or both. For any recipient identified in a QMB status, the provider should contact that recipient's eligibility worker at the local Department of Social Services prior to the start of care to receive assurance that the recipient's services will be covered.

**PERSONAL/RESPITE CARE RESPONSE TO REFERRAL**

The personal/respite care provider shall not begin services for which they expect Medicaid reimbursement until the admission packet is received from the Screening Team and not before the date authorized by the Screening Team on the DMAS-96. It is the responsibility of the provider to ensure that it receives a complete and correct screening packet prior to starting care.

Recipients who are already receiving an E&D Waiver service and wish to receive an additional service must have this additional service authorized through WVMI. The initial provider shall not begin services prior to the date on the WVMI letter authorizing the additional service. The initial provider must send a copy of the original screening packet, a copy of the WVMI authorization letter to add additional services, and a copy of the DMAS-122 to the new provider.

The personal/respite care provider has the authority and responsibility to determine, prior to accepting the referral from the Screening Team, whether the provider can adequately provide services to the recipient. No referral should be accepted unless the provider has the staff capability, and the recipient being referred appears appropriate for the provider's program. There may, however, be instances where the provider is unaware of a problem that will prohibit service delivery until the nurse supervisor completes the initial assessment.

Upon receipt of a referral and before the delivery of services, the registered nurse supervisor of the provider must make an evaluation visit to the recipient's home. During this initial home visit, the registered nurse supervisor is responsible for performing and documenting the following activities:

- Introduction of the aide to be assigned to the recipient - The RN or other staff may introduce the aide to the recipient during the initial visit or any time prior to the start of services (including the first day of service). This can be done via telephone;

- Discussion of the recipient's needs and review of the plan of care from the Screening Team; and

- Completion of the Provider Plan of Care (DMAS-97A) and review of this plan of care with the recipient or the recipient's family and the aide, or all, to ensure that there is complete understanding of the services that will be provided. The DMAS-97A (see "Exhibits" at the end of this chapter for a sample of this form) must be completed with the recipient's name, 12-digit Medicaid number, provider name and identification number, ADL composite score, RN signature, and start of care date. (This is the date that the personal care aide actually began providing care, and this date should also be the one used on the DMAS-122.) A copy of the current provider plan of care must be kept in the recipient's home. The aide should be instructed to use the provider plan of care (either the recipient's copy designating time increments or a copy that shows only the tasks checked) as a guide for daily service provision.

  It is appropriate for the aide to chart tasks that are not included in the recipient's plan of care if the recipient has a need for the task to be done. The aide should note why this task was performed and if the need for this task continues to exist. It is then the responsibility of the RN who reviews aide records to determine whether there is a need for the task to be included on the plan of care on an ongoing basis and make whatever changes are appropriate.

**RESPONSE TO INAPPROPRIATE AUTHORIZATION OF PERSONAL/RESPITE CARE SERVICES**

The provider should not initiate services if the RN determines one of the following during the initial assessment:

- The recipient is not appropriate due to health, safety, and welfare concerns;

- The provider cannot manage the recipient's care;

- An appropriate plan of care cannot be developed to meet the recipient's needs;

- The recipient does not meet the criteria for the waiver; or,

- The recipient does not meet the target population for the E&D Waiver.

If the provider determines that the provider should not initiate services, the provider must notify WVMI of this decision immediately. The provider is responsible for providing WVMI with the documentation supporting its decision. If WVMI agrees that the provider should not start services, WVMI must send a letter of notification to the recipient informing them of this and provide appeal rights.

The recipient will have 30 days to appeal the WVMI decision. Copies of the WVMI letter to the recipient will be sent to the provider and the Screening Team.

If WVMI disagrees with the provider's decision not to initiate care, WVMI will contact the agency in writing and inform them that services can be initiated.

If the provider does not initiate care because of the provider's inability to staff the case adequately, the provider must assist the recipient with locating another provider. If no provider who could staff the case is available in the community, the provider must inform the recipient of this in writing. Personal/respite care providers should, however, explore the possibility of ADHC as an alternative if the recipient is appropriate and that service is available in the community.

**DEFINITION OF PERSONAL CARE SERVICES**

Personal care services are defined as long-term maintenance or support services that are necessary to enable the recipient to remain at or return home rather than enter a nursing facility. Personal care services provide eligible recipients with Personal Care Aides who perform basic health-related services, such as helping with ambulation/exercises, assisting with self-administered medications, reporting changes in the recipient's condition and needs, or providing household services essential to health in the home, or all of these. Specifically, personal care services include assistance with personal hygiene, nutritional support, and the environmental maintenance necessary for recipients to remain in their homes. Personal care services cannot be offered to recipients who are residents of nursing facilities, assisted living facilities, or adult foster homes licensed or certified by the Department of Social Services.

**DEFINITION OF RESPITE CARE SERVICES**

Respite care is defined as services specifically designed to provide a temporary but periodic or routine relief to the primary, unpaid caregiver of a recipient who is incapacitated or dependent due to frailty or physical disability. This focus on the caregiver differentiates respite care from other programs which focus on the dependent or disabled recipient's need for care.

To receive respite services, the following criteria must be met:

- A primary, unpaid caregiver who lives in the home and who requires temporary relief from the stress of continual caregiving. Living in the home is defined as residing with the recipient under the same roof. The primary caregiver can maintain a separate legal residence, but must be staying with the recipient at all

times the primary caregiver is not employed;

- An incapacitated or dependent recipient who requires continuous and long-term care due to advanced age or physical disability;
- The respite services must be designed to relieve the physical and emotional burdens of the primary caregiver and, only secondarily, the needs of the recipient;
- The respite care must aid in the prevention of recipient or family breakdown and possible institutionalization of the recipient, which may result from the physical burden and emotional stress of providing continuous support and care to a dependent recipient; and
- The respite care must be provided in the recipient's home setting.

Respite care services can either be provided by a nursing assistant, or an LPN in cases where the recipient has a skilled nursing need. Respite care can be authorized as a sole Community-Based Care service or it can be offered in conjunction with another Community-Based Care service and be used routinely or used episodically for the relief of the primary caregiver.

An example of routine respite care is the authorization of one or two full days of service each week to allow the primary caregiver a routine break from the responsibilities of care giving. This might be an alternative to receiving daily personal care in areas where staffing is difficult. For example, if the live-in primary caregiver is not working, giving relief of one or two full days per week might be sufficient to prevent or delay nursing facility placement of the recipient. Examples of episodic respite include relief while the primary caregiver takes a vacation or has to leave town on a family emergency, relief while a primary caregiver is hospitalized, or is experiencing an illness, or wants to go out for an evening. Respite care will not be authorized for the relief of paid primary caregivers.

Respite care is the appropriate service when additional time is needed because the primary caregiver is ill. An increase in personal care hours cannot be given for this reason. Since respite care is for the relief of a primary caregiver, the primary caregiver does not necessarily have to be absent from the home. For example, if the primary caregiver sustains a back injury and is put on bedrest, respite care may be given to relieve the primary caregiver of his or her care-giving responsibilities during that time. Also, if respite care is given because the primary caregiver is hospitalized, respite care can continue once the primary caregiver returns home if a recuperation period is necessary.

In the situation when several children take turns staying at night with the recipient, respite care cannot be used if one of the caregivers becomes ill or takes a vacation because none of these individuals is the live-in primary caregiver.

Regardless of whether it is used routinely or episodically, respite care is limited to 720 hours in a calendar year. Recipients who exhaust their maximum amount of hours prior to the end of the authorization period must be informed that no additional hours will be

authorized. In these cases, they must wait until the calendar year has expired, and the provider contacts WVMI to request authorization for the next calendar year. This is not an automatic renewal, since a primary caregiver or recipient's needs and living situation may change.

Authorization for respite care may be made by the Screening Team (as a sole service), or may be added for a recipient already receiving personal care or adult day health care services. When respite is added as an additional service, WVMI must be contacted for authorization of the addition of respite care prior to the start of care. Only under emergency situations will a respite authorization be given retroactively. This will be reviewed on an individual basis by WVMI. In order for retroactive authorization to be considered for this reason, the provider must contact WVMI the first working day after the emergency.

A recipient's respite care year begins January 1 of each year through December 31 of the same year. The start of care date is entered into the computer for a one-year period; for example, from January 1, 2001-December 31, 2001, for the 720 hours total. If the recipient did not request respite care until June 1, 2001, he would have 720 hours from June 1, 2001 through December 31, 2001. The provider must track the number of respite hours used during the year. The provider does not need to send to WVMI the number of hours used each time that respite is provided.

It is essential for providers to track respite care hours for recipients who transfer from one provider to another. When a recipient transfers to a new provider, the new provider must know how many respite care hours the recipient has remaining for the current calendar year.

**COVERED SERVICES**

DMAS will only reimburse for services defined as personal/respite care services. Personal/respite care services to be provided by personal/respite care aides are limited to the following:

- Assisting with care of the teeth and mouth;
- Assisting with grooming (this would include care of the hair, shaving, and the ordinary care of the nails);
- Assisting with bathing of the recipient in bed, in the tub, the shower, or a sponge bath. Routine maintenance and care of external condom catheters is considered part of the bathing process; replacement of a colostomy bag as a part of the bath is included;
- Providing routine skin care, such as applying lotion to dry skin (not including any type of product with an "active ingredient" such as topical medications, alcohol, or witch hazel);
- Assisting the recipient with dressing and undressing;

- Assisting the recipient with turning and changing position, transferring, and ambulating;

- Assisting the recipient to move on and off of the bedpan, commode, or toilet;

- Assisting the recipient with eating or feeding, but does not include tube feedings;

- Assisting the recipient with self-administered medications and assuring that the recipient receives medications at prescribed times not to include in any way, determining the dosage of medication. The recipient/family member must be competent to direct the aide. The aide may assist the recipient with nebulizer treatments as long as the nebulizer medications are "unit dosed."

- Supervision is a covered service within the personal care plan of care when the purpose is to supervise or monitor those recipients who require the physical presence of the aide to ensure their safety during times when no other support system is available. The inclusion of supervision in the plan of care is appropriate only when the recipient cannot be left alone at any time due to mental or severe physical incapacitation. Recipients who cannot be left alone at any time are typically those who are disoriented and therefore, likely to wander or be a danger to themselves. This would also include recipients who cannot use a telephone to call for help due to a physical or neurological disability.

  Supervision will not be authorized for family members to sleep either during the day or during the night unless the recipient cannot be left alone at any time. Supervision cannot be considered necessary because the recipient's family or provider is generally concerned about leaving the recipient alone or would prefer to have someone with the recipient. There must be a clear and present danger to the recipient as a result of being left unsupervised. Supervision cannot be authorized for persons whose only need for supervision is for assistance exiting the home in the event of an emergency.

  Supervision can be authorized when there is no one else in the home competent to call for help in an emergency. In situations where an able caregiver is present to call for help but due to mental or physical disabilities, cannot provide for the recipient's physical needs (such as changing, transferring, turning, etc.), a split shift must be considered. If the recipient's primary caregiver has a business in the home, such as a day care center, supervision will only be considered if the recipient is dependent in orientation and behavior pattern.

  A personal/respite care aide cannot provide supervision to recipients who are on ventilators, or continuous tube feedings, or who require suctioning.

  The amount of supervision time included in the plan of care must be no more than is necessary to prevent physical deterioration of or injury to the recipient.

PERS may be explored in lieu of supervision.

- Administration of bowel programs by the aide under special training and supervision. The personal/respite care aide may be authorized to administer physician-ordered bowel programs to recipients who do not have any other support available. This authorization could only be given if the provider has documented (i) the aide has received special training in bowel program management, (ii) the aide has knowledge of the circumstances that require immediate reporting to the nurse supervisor, and (iii) the nurse supervisor has observed the aide performing this function. (This requirement applies to substitute aides as well.)

  The nurse supervisor is responsible for identifying and assessing those recipients thought to be appropriate for safe bowel management by the personal/respite care aide.

  Certain conditions exist that would contraindicate having the aide perform a bowel program, i.e., patients prone to dysreflexia such as high level quadriplegics, head and spinal cord injured patients, and some stroke patients. The bowel program may include, if necessary, a laxative, enemas, or suppositories to stimulate defecation. However, the laxative cannot be "administered" by the personal/respite care aide, even through part of the bowel program. (Suppositories are an exception to this and can be administered if ordered by the physician as part of a bowel program). Replacement of a colostomy bag as part of the bath is included. Digital stimulation and removal of feces within the rectal vault may be a necessary part of the bowel maintenance or training program. However, removal of impacted material is not permitted. (None of the procedures included here may be administered except as part of a physician-ordered bowel program.)

  The nurse supervisor must be available to the aide and be able to respond to any complications immediately;

- Administration of range of motion (ROM) exercises by the aide when instructed and supervised by the nurse supervisor. Range of motion exercises must be ordered annually by the physician. This order from the physician must specify that the recipient requires ROM and the frequency to be administered. ROM may be performed by the aide when the aide has been instructed by the nurse supervisor in the administration of ROM exercises, and the aide's correct performance of these exercises has been witnessed and documented by the nurse supervisor. Documentation must state that the aide is aware of the ROM order, trained in the performance of these exercises, and is competent in performing the ROM exercises. (This requirement applies to substitute aides as well.) This does not include strengthening exercises, resistance exercises, or exercises aimed at retraining muscle groups, but includes only those exercises used to maintain current range of movement without encountering resistance. The nurse supervisor will check the ROM on the supervisory visits and will make adjustments to the exercises with the physician as necessary.

- Routine wound care by the aide, which does not include sterile technique. Wound care (even routine) must be ordered by the physician. The aide can perform routine wound care which does not include sterile treatment or sterile dressings. This would include care of a routine decubitus, defined as a decubitus which is superficial or does not exceed stage I. Normal wound care would include washing the area, drying the area, and applying dry dressings as instructed by the nurse supervisor. This does not include the application of any creams, ointments, sprays, powders, or occlusive dressings (such as hydrocolloids and transparencies).

- Checking the temperature, pulse, respiration, and blood pressure and recording and reporting as required; and

- Home Maintenance Activities. These activities which are related to the maintenance of the home or preparation of meals should only be included on the plan of care for recipients who do not have an available caregiver. Individuals living in the home with the recipient who would be expected to perform housekeeping and cooking activities for themselves should provide the recipient's home maintenance activities while completing their own. For recipients who do not have someone either living in the home or routinely coming in to provide assistance, the following activities may be performed for the recipient only (not for other members of the family):

    - Preparing and serving meals, not to include menu planning for special diets;

    - Washing dishes and cleaning the kitchen;

    - Making the bed and changing linens;

    - Cleaning the recipient's bedroom, bathroom, and rooms used primarily by the personal care recipient;

    - Listing for purchase supplies needed by the recipient;

    - Shopping for necessary supplies for the recipient if no one else is available to perform the service; and

    - Washing the recipient’s laundry if no other family member is available or able.

    NOTE: Whenever an aide is performing any physician-ordered procedure, the RN must document on the DMAS-99 that the aide’s correct performance of the procedure is being observed. This must be documented at least quarterly.

DMAS will reimburse the provider only for services rendered to the recipient. DMAS will not reimburse the provider for services rendered to or for the convenience of other

members of the recipient's household (e.g., cleaning rooms used equally by all family members, cooking meals for the family, washing family dishes, family laundering, etc.).

Attending to Personal Care Needs of Recipients Who Work or Attend School, or Both

Recipients who wish to enter the E&D Waiver may continue to work or attend school, or both, while they receive services under this waiver. The personal care attendant who assists the recipient may accompany that person to work/school and may assist the person with personal care needs while the individual is at work/school. DMAS will pay for any personal care related services that are given by the aide to the enrolled recipient while the recipient is at work/school. DMAS will also pay for any personal care services that the aide gives to the enrolled recipient to assist him or her in getting ready for work/school or when he or she returns home.

DMAS will not pay for the aide to assist the enrolled recipient with any functions related to the recipient completing his or her job/school functions or for supervision time during work or school.

DMAS will review the recipient's needs and the complexity of the disability when determining the services that will be provided to the recipient in the workplace/school.

DMAS will not duplicate services that are required as a reasonable accommodation as a part of the Americans with Disabilities Act (ADA) or the Rehabilitation Act of 1973. For example, if the recipient's only need is for assistance during lunch, DMAS would not pay for the aide for any time extending beyond lunch. For a recipient whose speech is such that they cannot be understood without an interpreter (not translation of a foreign language), or the recipient is physically unable to speak or make himself understood even with a communication device, the aide's services may be necessary all day. DMAS will reimburse for the aide's services unless the aide is required to assist the recipient all day as a part of the ADA or the Rehabilitation Act of 1973.

The provider agency must develop an individualized plan of care which addresses the recipient's needs at home, work, and/or in the community.

Example: Mr. Jones is enrolled in the E&D Waiver. He works outside the home for five (5) hours each day. His attendant assists him with getting ready for work in the morning and accompanies Mr. Jones to work. The attendant may assist Mr. Jones with any personal care needs such as bathroom needs during the time that Mr. Jones is at work. Mr. Jones actually requires his attendant's assistance for a combined total of one (1) hour per day during the five-hour period that he is working, but the aide is providing supervision for the total five-hour period. The recipient's POC must include the full five hours for the provider to be reimbursed by DMAS. The provider must have authorization for supervision for this recipient.

Respite Care - Licensed Practical Nurse (LPN) Services

Through the respite care program, the provider may be reimbursed for the services of an LPN currently licensed to practice in the Commonwealth as long as the provider can document circumstances requiring the provision of services by an LPN. DMAS will reimburse for LPN respite care for only those recipients who require the skilled level of care and who have no support system other than the primary caregiver, (the recipient of respite care). The circumstances warranting provision of respite care by a LPN are:

- The recipient receiving care has a need for routine skilled care that cannot be provided by unlicensed personnel (e.g., patients on a ventilator, patients requiring nasogastric or gastrostomy feedings, suctioning, etc.);
- No other individual in the recipient's support system is able to provide the skilled component of the recipient's care during the caregiver's absence; and
- The recipient is unable to receive skilled nursing visits from any other source that could provide the skilled care usually given by the caregiver.

Under respite care services, an LPN can perform selected nursing procedures under the direction of a Registered Nurse (RN). Such selected procedures may include:

- Administration of medications;
- Care of tracheostomies, feeding tubes, etc.; and
- Wound care requiring sterile technique.

When an LPN is required, the LPN must also provide any of the services normally provided by an aide. The maximum amount of respite care services that a recipient under the E&D Waiver may receive is 720 hours in a calendar year.

**SERVICES EXCLUDED FROM COVERAGE/REIMBURSEMENT UNDER PERSONAL/RESPITE CARE**

DMAS will not reimburse providers for any services that are not listed above. Services that cannot be reimbursed include, but are not limited to, the following:

Transportation by an Aide

An aide is not allowed to transport a recipient (i.e., drive a vehicle for a recipient). The family or social support are expected to perform this service or make arrangements for alternate transportation (taxi, ambulance, etc.). Personal/respite care aides may not accompany a recipient and family on vacations or overnight trips. The personal/respite care aide may accompany the recipient, however, if all of the following criteria are met:

- The recipient is being transported to an essential medical appointment.

Outpatient therapy appointments, such as physical therapy, occupational therapy, speech therapy and aquatic therapy, and dialysis appointments are excluded. An aide may not accompany a recipient to the hospital when the recipient is being transported by ambulance;

- The aide is essential for the safe transport of the recipient (to assist in transfers, ambulation, behavior management, etc.);
- No other individual is available and physically able to accompany the recipient;
- The total time required by the aide for the day, including the time required to accompany the recipient, does not cause the recipient's weekly authorized hours to be exceeded; the provider must call WVMI the next business day with the actual hours used for authorization of hours exceeded in the previous day's clinic appointment. It must be documented in the record why the hours were exceeded or the additional time may be deducted from another day as long as this does not jeopardize the recipient's health and safety;
- The RN supervisor has been notified in advance of the appointment, and the RN has approved, documented, and dated in the RN notes in the recipient's record; and
- When the aide is required to accompany the recipient based on the above criteria, DMAS will reimburse the provider for the time the aide is accompanying the recipient to such medical appointments. This must be documented on the aide's record.

Skilled Services

Services requiring professional skills or invasive therapies, such as tube feedings, indwelling catheter irrigations, sterile dressings, or any other procedures requiring sterile technique, cannot be performed by personal/respite care aides. Routine maintenance and care of external condom catheters does not constitute a skilled service and can be performed by the aide as part of the bathing process.

## RELATION TO OTHER MEDICAID-FUNDED HOME CARE SERVICES

Virginia currently offers two other home-based services through the Virginia *State Plan for Medical Assistance*: Home Health and Hospice care.

Home Health

The major differences between home health and personal care services are the increased involvement of professional medical personnel in home health services and the emphasis in home health on short-term, intermittent, restorative care rather than long-term maintenance functions. A home health aide shall be assigned when the responsible physician has

specified in the recipient's plan of care the need for such a service. This plan of care must be re-evaluated and signed by the responsible physician not less than once every 60 days. The registered nurse shall make a supervisory visit to the recipient's residence at least every two weeks to assess relationships and determine whether goals are being met.

Hospice Care

Hospice is an autonomous, centrally administered, medically directed program providing a continuum of home, outpatient, and homelike inpatient care for the terminally ill patient and his or her family. It employs an interdisciplinary team to assist in providing palliative care to meet the special needs arising out of the physical, emotional, spiritual, social, and economic stresses which are experienced during the final stages of illness and during bereavement. The goal is to maintain the recipient at home for as long as possible while providing the best care available to the patient, thereby avoiding institutionalization.

To be covered, the recipient must elect hospice services, and his or her terminal illness (prognosis of usually has six months or less) must be certified by the recipient's attending physician and the hospice medical director. A hospice must routinely provide a core set of services including nursing care, physician services, social work, and counseling.

Simultaneous Provision of Personal Care and Hospice Services

The following information is applicable regardless of whether the hospice receives reimbursement from Medicare or Medicaid for the services covered under the hospice benefit.

The hospice benefit provides comprehensive services to persons with terminal illness. The hospice provider must offer homemaker/home health aide services as a part of the hospice benefit. Based upon the Medicare policy establishing the hospice reimbursement rates, it has been determined that the daily reimbursement rate covers the cost of providing a minimum of three hours per day of homemaker/home health aide services. The hospice provider must cover a minimum of 21 hours per week of homemaker/home health aide services for any recipient who requires those services. Personal care under the E&D Waiver will not be available to the hospice recipient unless the hospice can document the provision of at least 21 hours per week of homemaker/home health aide services and that the recipient needs personal care-type services which exceed this amount.

Personal care services provide a cost-effective alternative to nursing facility care. This means that the cost to Medicaid for the recipient to receive care in the community must be equal to or less than the cost to Medicaid for that same recipient to receive care in a nursing facility. If a recipient is receiving hospice services, the maximum amount of personal care services that is cost-effective is 5.5 hours per day (a maximum of 38.5 hours per week). This amount is based upon a comparison of the cost to Medicaid for a recipient in the community receiving both services and the cost to Medicaid for that recipient in a nursing facility and receiving hospice services.

Once a recipient elects the hospice benefit, the hospice becomes responsible for establishing an interdisciplinary plan of care designed to meet the individual needs of the

recipient. If at the time of the hospice assessment, the recipient's needs indicate that more than 21 hours per week are needed and these hours cannot be met by hospice staff, volunteers, the family support system, or other community resources, the recipient should be referred to a Nursing Home Pre-admission Screening Team (Screening Team). The Screening Team will evaluate whether the recipient meets the criteria for the E&D Waiver. If a recipient is receiving personal care services at the time that he or she elects the hospice benefit, and the criteria for receiving combined services are met, the hospice provider must send a copy of the interdisciplinary team plan of care with the hospice enrollment forms to avoid the automatic termination of the prior personal care authorization.

When personal care services are requested in addition to the services being provided under the hospice benefit, Screening Teams must:

- Determine the recipient's total needs for home care including an estimate of the daily number of hours required and document this on the Uniform Assessment Instrument (UAI) in the summary section;
- Indicate the name of the hospice involved on page 12 of the UAI and on the DMAS-97; and
- Authorize personal care, as long as the recipient will be safe in the home setting with the total amount of care available through personal care, hospice, and informal supports.

When submitting the personal care enrollment package to WVMI for preauthorization, the provider must include a copy of the hospice interdisciplinary team plan of care so that WVMI can allow reimbursement for simultaneous services. The hospice must coordinate with the personal care provider to establish and agree upon one plan of care for both providers which reflects the hospice philosophy and is based on an assessment of the recipient's needs and unique living situation. The recipient and service providers must be involved in any and all decisions that affect the recipient's care. If a hospice provider contracts with the personal care provider for the 21 hours of aide service under hospice, the aide must complete a DMAS-90 (Aide Records) only for the time billed to personal care.

If a recipient receiving both personal care and hospice needs respite care, the hospice provider is required to provide respite care coverage.

The election of the hospice benefit is the recipient's choice rather than the hospice's choice. The hospice benefit is not designed to meet the needs of every terminally ill recipient. The recipient and family must be fully informed of the services available and any limitation on those services prior to electing the benefit. Some recipients' needs may be more effectively met by utilizing other state and local programs and services. Once a recipient has been accepted for care, the hospice may not discharge the recipient at its discretion, even if the recipient's care becomes costly or inconvenient. The recipient must sign a revocation of hospice benefits in order for him or her to be discharged from hospice services.

For specific questions about the provision of personal care and hospice services, contact either WVMI at (804) 648-3159 in Richmond (or 1-800-299-9864 all other areas) or the DMAS Facility and Home-Based Services Unit at (804) 225-4222.

**DEVELOPMENT OF THE PLAN OF CARE (DMAS-97A) FOR PERSONAL/RESPITE CARE SERVICES**

The DMAS-97A must be completed by the provider's RN prior to the start of care for any recipient. The Screening Team plan of care indicates to the personal/respite care provider the general needs of the recipient. The personal/respite care provider should allocate time for the four service categories (which include 19 specific personal/respite care tasks) listed on the DMAS-97A. The RN supervisor's assessment visit should note any special considerations for service provision and the support available to the recipient. Time does not need to be allocated for each of the 19 tasks on the plan of care; these should only be either checked or a description given, if necessary. Each sub-category should be totaled if time has been allotted to that category (Activities of Daily Living (ADL), Special Maintenance, and Housekeeping).

Each recipient is assigned a level of care based on his or her composite ADL score. The composite ADL score is the sum of a rating of six ADL categories. These six categories are bathing, dressing, transfers, ambulation, eating, and continency. The provider should assign a rating for each ADL category which best describes the recipient based on the RN supervisor's observation at the time of the initial home evaluation. Each of these six categories are scored as follows:

| | | ADL RATING |
|---|---|---|
| Bathing: | Bathes without help or with Mechanical Help (MH)<br>MH only | 0 |
| | Bathes w/ Human Help (HH)<br>Or w/ HH & MH | 1 |
| | Is bathed | 2 |
| Dressing: | Dresses without help or w/MH only | 0 |
| | Dresses w/ HH or w/ HH & MH | 1 |
| | Is dressed or does not dress | 2 |
| Transfers: | Transfers without help or w/MH only | 0 |
| | Transfers w/ HH or w/ HH & MH | 1 |
| | Is transferred or does not transfer | 2 |

| | | ADL RATING |
|---|---|---|
| Ambulation: | Walks/Wheels without help or w/MH only | 0 |
| | Walks/Wheels w/ HH or HH & MH | 1 |
| | Totally Dependent for Mobility | 2 |
| Eating: | Eats without help or w/ MH only | 0 |
| | Eats w/ HH or HH & MH | 1 |
| | Is fed: spoon/tube fed, IV, etc. | 2 |
| Continency: | Continent /Incontinent < weekly/ self-care of internal/external devices | 0 |
| | Incontinent weekly or more/ Not self-care | 2 |

Once the recipient's composite score is derived, a level of care is designated for that recipient as either Level A, B, or C. The designation of a level of care is important because the level of care determines the maximum number of hours per week of personal care services that the recipient may have allocated to his or her plan of care. Any hours beyond the maximum for the recipient's level of care must be preauthorized by WVMI. Any plan of care submitted without approval for hours beyond the maximum for any particular level of care will only be entered for the maximum for that level of care. Once WVMI authorization is received, the number of hours can be increased. However, the increase in hours will not be made retroactive. Each level of care category has a maximum amount of hours for that level. The categories, composite scores, and maximum hours are as follows:

LOC A
(score 0-6)
Maximum Hours 25

LOC B
(score 7-12)
Maximum Hours 30 per week

LOC C
(score 9+ Wounds, Tube feedings, etc.)
Maximum Hours 35

Prior to designating the level of care, however, the provider should develop the plan of care to reflect the needs of the recipient and not necessarily the maximum amount of service that the recipient is able to have based on his or her level of care. This maximum is based on a seven-day per week plan of care. The provider is allowed to develop a plan of care and subsequently make changes to the plan of care without prior approval from WVMI as long as the recipient's amount of service does not exceed the maximum amount established for that recipient's level of care and as long as supervision is not being added as a new service. Supervision can be added to the plan of care without authorization if it has been

pre-approved on the DMAS-97 by the Nursing Home Pre-admission Screening Team (NHPAS). The provider must submit, to WVMI, the change of hours for billing purposes. Reimbursement for the full amount of services included in the plan of care and rendered by the provider may be denied when the recipient's plan of care is inflated beyond the needs of the recipient.

**Level of Care A** - The recipient's score is 6 or less on the ADL composite rating and the recipient has medical/nursing needs. Recipients in Level of Care (LOC) A are the most functionally capable group in personal/respite care and therefore, should usually require the least amount of services (anywhere from 7.5 to 17.5 hours per week). The maximum amount of time per week that a recipient in LOC A may be provided services has been established at 25 hours per week. This maximum is based on a seven-day-per-week plan of care with an average daily need for ADL care of two (2) hours/day and housekeeping of one and one half (1.5) hours per day. Although the provider may use the maximum allowed for the level of care, it is expected that recipients will not routinely require maximum amounts of care. Within the level of care, the amount of time required to perform ADL and housekeeping tasks will vary.

The following guidelines are intended to assist the provider to determine the appropriate allocations of ADL time for recipients within LOC A. All recipients in LOC A probably require more time for housekeeping tasks since they are more likely to live alone and occupy more living area.

1. Minimal Needs - These are the least dependent recipients, often borderline in meeting the criteria for nursing facility care (ADL score 2-3). The recipient may require prompting rather than hands-on assistance, may use mechanical help more than human help with a need for stand-by assistance:

   Average time allocated for ADL's - .75 - 1 hr/day
   Average time for Housekeeping - 1 - 1.5 hr/day

2. Average Needs - These recipients have somewhat more need for hands-on help, stand-by assist, and are somewhat more dependent (ADL score 3-4):

   Average time allocated for ADL's - 1 - 1.5 hr/day
   Average time for Housekeeping - 1 - 1.5 hr/day

3. Heavy Needs - These recipients will require some help in all areas of ADL care although they will usually be mobile and can probably eat without assistance (ADL score 4-6):

   Average time allocated for ADL's - 1.5 - 2 hr/day
   Average time for Housekeeping - 1 - 1.5 hr/day

**Level of Care B** - The recipient's score is between 7-12 on the ADL composite rating. Recipients in this category are the least functionally capable group with medical/nursing needs in personal/respite care. These recipients will probably require an average of from 15 to 28 hours per week. The maximum amount of time per week that a recipient in LOC

B has been established at 30 hours per week, with an average daily need for ADL care of 2.5 hours/day and housekeeping of 1.75 hours per day. This maximum is based on a seven-day per week plan of care. Although the provider may use the maximum allowed for the level of care, it is expected that recipients will not routinely require maximum amounts of care.

The following guidelines are intended to assist the provider to determine the appropriate allocations of ADL time for recipients within LOC B. Within this level of care, the amount of time required to perform ADL and housekeeping will vary. Recipients in LOC B probably require between the heavy time allocated in LOC A and an average amount of time for housekeeping tasks. The population in LOC B may have more recipients who have a live-in caregiver and who occupy less living area.

1. Minimal Needs - These recipients may require assistance to ambulate, but are still able to perform some tasks for themselves (ADL score 7-8):

   Average time allocated for ADL's - 1.5 - 2 hr/day
   Average time for Housekeeping - 1 - 1.75 hr/day

2. Average Needs - These recipients may require an assist to transfer as well as ambulate, eat, toilet, most ADL's (ADL score 9-10):

   Average time allocated for ADL's - 2 - 2.5 hr/day
   Average time for Housekeeping - 1 - 1.75 hr/day

3. Heavy Needs - These recipients will require the maximum amount of help in all areas of ADL care. They will usually be bed-confined and therefore, may actually take less time to render services than the recipient who performs some self-care but requires assistance (ADL score 11-12):

   Average time allocated for ADL's - 1.5 - 2.5 hr/day
   Average time for Housekeeping - 1 - 1.75 hr/day

**Level of Care C** - The recipient's score is 9 or more on the ADL composite rating and in addition has a skilled medical/nursing need. Examples of skilled needs are wound care (greater than Stage I decubitus), tube feedings, trach care, suctioning, and ventilator care. Note: These needs merely qualify a recipient to be rated as LOC C. Personal care aides cannot participate in assisting recipients with these needs. Recipients in LOC C are the least functionally capable group and must have skilled medical/nursing needs. These recipients will probably require an average of from 20 to 30 hours per week. The maximum amount of time per week that a recipient in LOC C may be provided services has been established at 35 hours per week, with an average daily need for ADL care of three (3) hours per day and housekeeping of two (2) hours per day. Although the provider may use the maximum allowed for the level of care, it is expected that recipients will not routinely require maximum amounts of care.

The following guidelines are intended to assist the provider with determining the appropriate allocations of ADL time for recipients within LOC C. Within this level of

care, the amount of time required to perform ADL and housekeeping tasks may vary. Recipients in LOC C probably require the least amount of time for housekeeping tasks since the population in LOC C will usually have a live-in caregiver who will perform most housekeeping and shopping duties.

1. Minimal Needs - These recipients may have the maximum in-home support and fewer special maintenance needs. Some of the recipients in this minimum range of needs within LOC C will actually be quite dependent, but may be cared for quickly merely because they do not participate in their own care:

   Average time allocated for ADL's - 1.5 - 2 hr/day
   Average time for Housekeeping - 1 - 2 hr/day

2. Average Needs - These recipients will generally require more ADL time to prevent skin breakdown by frequent turning, may require wound care, feedings completed by the family, etc., and have only moderate support to assist with this care:

   Average time allocated for ADL's - 2 - 3 hr/day
   Average time for Housekeeping - 1 - 2 hr/day

3. Heavy Needs - These recipients may be new quadriplegics, have a degenerative disease and generally will be the most difficult recipients to maintain in their homes due to their many maintenance needs:

   Average time allocated for ADL's - 2 - 3 hr/day
   Average time for Housekeeping - 1 - 2 hr/day

The maximum amount of care established for all levels of care were not established with regard to the need for supervision as a personal/respite care task. A recipient in any level of care may require 24-hour-a-day supervision due to confusion, disorientation, wandering or aggressive behavior, or inability to remain safely alone due to physical condition and social support. Additional time can be added to the plan of care beyond the maximum amount of time for that recipient's level of care, but this plan of care requires prior authorization from WVMI. Personal Emergency Response Systems (PERS) may be an appropriate services for a recipient who requires supervision. PERS may only be provided to recipients who, if not for the service, would require supervision. PERS should only be used to replace supervision, not add to it.

If the recipient requires more supervision and time beyond that which is provided through the personal care time allowed for ADL's and housekeeping, and the provider is requesting time for supervision, the recipient must have a support system that is able to provide those additional supervision needs. Recipients who have supervision time in the plan of care must have someone with them 24 hours a day. The provider must document on the DMAS-99 the need for supervision and the plan for the recipient's care during times when the aide will not be in the home. If supervision time is included in the recipient's plan of care, the RN supervisor must document this information on the DMAS-100 (Request for Supervision form).

The Department of Medical Assistance Services will not reimburse for 24-hour-per-day care through personal care, as this level of service cannot be shown as a cost-effective alternative to nursing facility care.

It is important to recognize that the guidelines provided reflect the way in which WVMI will review plans of care submitted. However, since the level of care does not reflect the medical needs of the recipient as per the diagnosis and recent history or reflect the idiosyncrasies of that recipient's personality or environment, the guidelines cannot fully capture the range of needs and support which the provider may encounter. For instance, housekeeping needs will vary according to the abilities of the recipient as reflected in the level of care and according to the amount of social support received from either a live-in caregiver or some other family or community support. The amount of time required for housekeeping may also be affected by other factors, such as the presence of on-site laundry facilities, the lack of modern plumbing, heating, and cooking facilities. It is, however, only in very unusual circumstances that a plan of care would contain more than two (2) hours per day for housekeeping and meal preparation (combined). These unusual circumstances should be clearly documented on the DMAS-97A. In no circumstances where the recipient has a live in caregiver should the hours allotted in this category exceed two (2) hours per day. The provider is expected to use professional judgment to determine the amount of service needed by the recipient. Documentation must support the amount of hours provided to the recipient. As long as the amount is within the maximum established for that level of care and the decision process can be documented and appears logical, DMAS will not deny reimbursement for services.

**RESPONSIBILITIES OF THE PROVIDER FOR MONITORING FOR PERSONAL/RESPITE CARE SERVICES**

The provider is responsible for monitoring the ongoing provision of services to each Medicaid recipient. This monitoring includes:

- The quality of care provided by the aide;
- The functional and medical needs of the recipient and any modification necessary to the plan of care due to a change in these needs; and
- The recipient’s need for support in addition to care provided by personal/respite care. This includes an overall assessment of the recipient's safety and welfare in the home with personal/respite care.

<u>RN Responsibilities/Required Documentation</u>

1. 30-Day Supervisory Visits: The RN supervisor must conduct supervisory visits to the recipient’s home as often as needed to ensure both the quality and appropriateness of services. A minimum frequency of these visits is at least every 30 calendar days. During these visits, the RN supervisor will provide any necessary supervision to the aide and recipient and record all significant contacts in the recipient’s file. During visits to the recipient’s home, the RN supervisor

must observe, evaluate, and document the adequacy and appropriateness of personal/respite care or PERS services with regard to the recipient's current functional status and medical and social needs. The aide's record must be reviewed, and the recipient's (or family's) satisfaction with the type and amount of services must be discussed.

Personal and respite care providers must use the DMAS-99, Community-Based Care Recipient Assessment Report, to document the findings of these visits. The RN supervisor must completely assess the recipient every 30 days and document all the elements noted on the DMAS-99 each time a visit is made. The aide must be present during the nursing supervisor's visit at least every other visit. If the aide is always present during the RN supervisory visit, then every other month the RN supervisor must make a telephone contact to the family or recipient during non-personal care hours to assess the family and recipient's satisfaction with services. This telephone conversation must be documented in the recipient's record. This gives the family or the recipient, or both, the ability to address any concerns or issues without the presence of the aide.

Documentation must comply with DMAS requirements. The provider may use whatever additional documentation it feels necessary.

The RN supervisor summary must note:

- Any change in the previously documented recipient's medical condition, functional status, and social support. The RN supervisor is expected to know the nursing facility criteria in "Exhibits" at the end of this chapter and to apply these criteria when assessing whether the recipient continues to meet the criteria to receive personal/respite care services. If the RN supervisor determines that the recipient does not meet the criteria for personal/respite care services, the RN supervisor must contact WVMI to discuss termination;

- Whether the plan of care is adequate to meet the recipient's needs or if changes need to be made;

- Dates of any lapse of services and why (e.g., hospitalization admission and discharge dates, aide not available, etc.);

- The presence or absence of the aide in the home during the visit; and

- Any other services received by the recipient.

In addition to the routine information, which must be documented in the RN supervisor's 30-day summary, there are several areas which require special monthly documentation by the RN supervisor. These areas were addressed earlier in this chapter and are outlined below:

Supervision – The identification and need for supervision as a part of a

recipient's plan of care must be preauthorized by the Screening Team during the screening process. If the Screening Team identifies supervision as a needed service (on the DMAS-97 form), and the RN supervisor identifies it as a needed service on the plan of care, the RN supervisor may include supervision with authorization up to the maximum amount of hours for that level of care. If the addition of supervision hours will extend beyond the level of care cap, the RN supervisor must call WVMI for preauthorization to include this in the plan of care. If the RN supervisor is not authorized on the DMAS-97, and during the initial assessment, the RN supervisor determines there is a need for it, then the RN supervisor must obtain authorization from WVMI prior to implementation.

In all instances in which RN supervisory time will be incorporated in the plan of care, and the total hours will exceed the number of hours allowed for the recipient's level of care, the RN supervisor must contact WVMI to discuss the hours and needed services, and obtain prior authorization for hours above the level of care (LOC). The effective date for authorization for hours will be given at the time of the approval. DMAS will not reimburse retroactively for hours over the LOC which were provided prior to the WVMI authorization date.

In every case in which the RN supervisor has identified the need for supervision to be included in the recipient's plan of care, the following documentation requirements must be met:

- The RN supervisor must complete a DMAS-100 (Request for Supervision form). This form must include the reason supervision is needed, the amount of supervision needed, and that the ability of all other support persons to provide supervision has been explored, and must identify who will provide supervision in the absence of the personal/respite care aide;

- The RN supervisor must document on the recipient's record his or her contact and conversation with the analyst at WVMI. (It is imperative that these notes include the date and time of the call, the name of the analyst to whom he or she spoke, and the final decisions and effective date for the hours requested.);

- A copy of the analyst's approval letter must be maintained in the recipient's file; and

- In no circumstances may the time allotted for supervision on the plan of care exceed eight (8) hours in a day.

Bowel Program - A written physician's order in the recipient's file must specify the method and type of digital stimulation and frequency of administration. A new physician's order must be obtained every six (6) months or more frequently if changes in the recipient's condition occur. The RN supervisor must document that (i) the aide has received special training in bowel program management, (ii) the aide has knowledge of the circumstances that require immediate reporting to the nurse supervisor and contraindications as to when

the aide cannot administer the bowel program (e.g. cardiac, dysreflexia, diarrhea, etc.), and (iii) the nurse supervisor has observed the aide performing this function. No manual disimpaction by the aide is permitted. Changing colostomy bags or emptying bags is permissible with RN supervisor instruction and return demonstration. Fleet enemas may be administered with a physician's order and RN supervision. The aide's continued understanding and ability to perform bowel programs must also be observed and documented in the nursing note at least every 90 days.

Range of Motion Exercises - The written physician order that indicates the need and extent of range of motion exercises, which are to be performed, must be in the recipient's file. A new physician's order must be obtained every six (6) months or more frequently if changes in the recipient's condition occur. The RN supervisor must document in the recipient record that the aide has been instructed by the RN supervisor in the administration of range of motion exercises and that the aide's correct performance of these exercises has been observed and documented by the RN supervisor. The continued need for range of motion exercises and the monitoring of the aide's performance of these exercises must be noted in the nursing note at least every 90 days.

Routine Wound Care - Each month the RN supervisor must document the status of the wound and the monitoring of the aide's care. There must be a specific physician's order in the recipient's record, and a new order must be obtained at least every six (6) months or more frequently if changes in the recipient's occur.

Catheter Care - When routine care of a urinary catheter is to be provided by the personal care aide, the RN supervisor must indicate in the initial RN supervisory note that the aide is providing catheter care and what instructions the aide has received from the RN supervisor regarding this care. For condom catheters, the RN supervisor must observe the initial application of the condom catheter and documentation must indicate the aide's ability to perform this procedure. The same procedure must be followed when substitute aides are providing condom catheter care.

The RN supervisor must note and follow-up on any concerns related by the recipient, family, or primary caregiver, aide, or other involved professional. Any time the permanently assigned aide changes, the recipient must be notified and it should be documented in the recipient's record. Recipient notification can be done by a RN supervisor or other staff and can be done by telephone.

The RN supervisor is responsible for taking appropriate action to ensure continued appropriate and adequate service to all recipients. Appropriate actions may include: counseling an aide about the care to be provided to the recipient, requesting from WVMI an increase to the recipient's plan of care to include supervision, discussing with the recipient's family the need for additional care for the recipient, or contacting WVMI to request a special review of the recipient's case. Any time the provider is unsure of the

action that needs to be taken, the provider should contact a WVMI review analyst for consultation.

Changes to the Plan of Care

The RN supervisor is responsible for making modifications to the plan of care as needed to ensure that the aide and recipient (or family) are aware of the tasks to be performed and that the hours and type of care are appropriate to meet the current needs of the recipient. The provider must establish the amount of service in the plan of care appropriate to meet the recipient's needs as long as the following apply:

- The maximum number of hours per week for that recipient's level of care is not exceeded, and
- The increase in service level is not a result of adding supervision to the plan of care.

Any time the number of hours for a recipient needs to be changed, a provider must develop a new plan of care. The most recent plan of care must always be in the recipient's home. The provider must either complete a new plan of care at least annually or document on the current plan of care annually that the plan of care was reviewed and no changes are necessary. If there are no changes to this annually updated plan of care, there is no need to send it to WVMI. Copies of all plans of care must be maintained in the recipient's file at the provider. These plans of care and documentation of service delivery must be consistent with the information submitted to WVMI or communicated to WVMI by telephone when contacted for an authorization.

Changes of hours (decreases or increases within a recipient's level of care) should be submitted to WVMI, using the DMAS-98, Community Based Care Request for Services form (found in "Exhibits" at the end of this chapter). The provider may document the increase/decrease within the level of care directly on the CBC Request for Services form. However, if the hours are crossing the recipient's current level of care, (the recipient was a level of care A, and is now a level of care B; or a level of care B and is now a level of care C and in need of increased hours), the provider must submit to WVMI the new plan of care reflecting the revised hours and updated composite ADL score reflecting the change in level of care. It should be noted that it is at WVMI's discretion to request plans of care, or any supporting documentation at any time to support the analysts' decisions. Providers are required to submit changes in hours when they occur. Do not submit changes in hours at the end of the month. Always use the CBC Request for Services form (DMAS-98) when submitting any request. The monthly change in hour forms should not be utilized or submitted to WVMI.

The provider must follow the procedures to request an authorization whenever a change in the recipient's condition (physical, mental, or social) indicates that:

- The recipient requires supervision to be added to the plan of care even if the recipient's hours will be within the level-of-care category (preauthorization is

not required if supervision is authorized on the DMAS-97 and hours do not exceed level-of-care category); or

- An increase in the plan of care is needed for more than the amount allowed according to the recipient's current level of care.

When it is identified, either upon admission of a new personal care recipient or after services have been initiated, that a recipient requires a change to the plan of care, as outlined above, the following describes the procedures to be taken:

The RN supervisor must contact the WVMI, CBC Review Unit at (804) 648-3159-Richmond or 1-(800)- 299-9864-all other areas- and speak to the review analyst. The provider may also fax or mail the request. The RN supervisor must have the following information available in order to discuss the case with the review analyst:

Name of requesting RN
Name and ID # of provider
Address of provider
Total weekly hours requested for the new plan of care and the reason the hours are needed

Name of recipient
Recipient's Medicaid number
Current hours on the plan of care
Effective date being requested for the new plan of care

The RN supervisor must be thoroughly familiar with the recipient's condition and the recipient's social support system. If supervision is being requested while the caregiver works, the provider may be asked to obtain a note from the caregiver's employer verifying the work schedule.

The RN supervisor must document the discussion with the WVMI analyst. This provider documentation must include the time and date of the call, the name of the analyst to whom the RN supervisor spoke and the outcome decision from the conversation. If the WVMI analyst has requested additional information and not yet approved the hours or services, that too should be documented.

If supervision time is being requested, the RN supervisor must complete the two-page Request for Supervision form (DMAS-100). This form must be completed for each recipient who has time allotted in the supervision category on the plan of care. The analyst may request that this supervision request form and plan of care be faxed to WVMI. The most recent RN supervisory visit (DMAS-99) may also be required.

The WVMI analyst will complete an authorization or denial form and send it to the provider. The provider, in turn, must forward a copy of this letter to the recipient. Recipients have the right to appeal any adverse action taken by WVMI. A copy of this letter must be maintained in the recipient's record.

All provider issues for the WVMI CBC Review Unit will be handled by the analyst(s) assigned to telephone duty on the day the call comes in.

Aide Responsibilities/Required Documentation

The aide is responsible for following the plan of care, notifying the RN supervisor of any change in condition, support or problem that arises and documenting the performance of duties on the Aide Record (DMAS-90). The aide must document on the Aide Record the specific services delivered to the recipient and the recipient's response. This record must also contain the arrival and departure time of the aide. The aide must record comments or observations about the recipient on a weekly basis. Aide comments should include observation of the recipient's physical and emotional condition, daily activities, and the recipient's response to services rendered. The aide and the recipient must sign the Aide Record once each week to verify that personal care services have been rendered. Documentation on logs must be in the English language. Signature, times, and dates must not be placed on the DMAS-90 prior to the last day of the week that the services are delivered. If the recipient is unable to sign the Aide Record, a family member or friend may sign. If no other person is able to sign the Aide Record, the recipient may make an "X". If the recipient is unable to sign or make an "X", a notation must be made in the front of each recipient record that "recipient is unable to sign."

The Aide Record must be completed on a daily basis on the day the service was delivered. The DMAS-90 is designed to contain one calendar week of service provision and should be utilized in this manner. Agencies may not, in any way, make changes to the DMAS-90 to suit an individual provider's needs.

Any corrections needed to the aide record should be made by drawing a line through the incorrect entry and re-entering the correct information. Whiteout must never be used for correction. Copies of all Aide Records are subject to review by State and federal Medicaid representatives. The records contained in the chart must be current within two weeks at all times.

It is the responsibility of the provider to ensure that the Aide Records are delivered to the provider and filed in the recipient's record within two (2) weeks. Periodic review of the aide's record must be done prior to filing it in the record to ensure that the RN supervisor is aware of any change in the recipient's needs documented by the aide or any change in the plan of care which may be indicated by the aide's charting. An accurately signed and dated Aide Record is the only authorized documentation of services provided for which DMAS will reimburse.

In addition to the RN and aide documentation, at a minimum, the recipient's record must contain the Uniform Assessment Instrument (UAI), the Consent for Exchange of Information (DMAS-20), the Nursing Home Pre-Admission Screening Authorization (DMAS-96), the Screening Team Plan of Care (DMAS-97), the provider Plan of Care (DMAS-97A), and the DMAS-101 (if applicable). Copies of these forms are in "Exhibits" at the end of this chapter.

Recipient Health and Safety Issues

If the provider becomes aware that the services being provided and the recipient's current support system may not adequately provide for the recipient's safety, the provider should immediately contact the WVMI review analyst to discuss the case specifics. The intent of this discussion is to determine whether the recipient's current status represents a potential risk or an actual threat to his or her safety, health, and welfare.

A potential risk is identified as deterioration in either the recipient's condition or environment, or both, which, in the absence of additional support, could result in harm or injury to the recipient.

An actual threat is the presence of harm or injury to the recipient which can be attributed to the recipient's deterioration and lack of adequate support (e.g., the recipient becomes anemic, malnourished, or dehydrated due to the inability to obtain food and water; the recipient develops decubitus due to lying in urine or feces, etc.).

To determine whether an actual threat may exist, the provider should consider the following:

1. Is the recipient capable of calling for help when needed?
2. Is there a support system available for the recipient to call?
3. Can conditions be arranged for the recipient to care for basic needs when the support system is absent?
4. Is the recipient medically at risk when left alone?
5. Has some harm or injury to the patient been reported?
6. Does the recipient express fear or concern for his or her welfare?

If answers to the above indicate a potential risk, the provider should still advise WVMI of the situation. WVMI will decide if health, safety, and welfare are an issue and if any other referrals are necessary, for example Adult Protective Services (APS).

When a real threat to the recipient's health, safety and welfare exists, WVMI will attempt to assess whether additional services can be obtained to maintain the recipient in a home environment. If continued maintenance in the home is not possible, the analyst will initiate procedures to terminate services and advise the recipient, family, or primary caregiver that nursing facility services should be considered. (Information regarding the procedures to transfer a recipient from personal care services to a nursing facility is included later in this chapter.) If the recipient or family refuses nursing facility placement, the provider RN supervisor must report the situation to APS. For the provider's protection, a letter from the provider should follow up a telephone call to APS. Waiver services may be terminated if a safe plan of care cannot be developed.

## PERSONAL CARE PROVIDER RECIPIENT PROGRESS REPORT

Federal regulations require that each individual authorized for waiver services be evaluated on an annual basis to assure that the individual continues to meet the criteria for the waiver and that the services offered through the waiver are appropriate and adequate to meet the needs of the individual.

The provider RN supervisor is responsible for completely describing the recipient's functional status, medical/nursing needs, and the appropriateness of the plan of care every six months. The functional status assessment should be completed using the DMAS definitions found in the Appendix. These definitions are the same as those used by DMAS and the Nursing Home Pre-Admission Screening Team to determine whether the individual meets the functional status component of the nursing facility criteria. The completion of the Community-Based Care Recipient Plan of Care Review and Assessment Report (DMAS-99) substitutes for the required 30-day RN supervisory note during the month in which this form is submitted. A copy of this form is found in the Appendix.

## SPLIT-SHIFT SERVICE DELIVERY

There are situations in which the recipient may benefit from services offered during two distinct shifts during the day (i.e., morning and evening). The provider should complete two plans of care, labeled morning or afternoon, to indicate each shift of services. The total number of hours on morning and afternoon plans of care combined cannot exceed the number allowed for the recipient's level of care without prior approval from WVMI.

## PROVISION OF PERSONAL/RESPITE CARE SERVICES TO MORE THAN ONE RECIPIENT IN THE SAME HOUSEHOLD

The personal/respite provider will assess the needs of all authorized recipients independently and develop the amount of time required for each recipient for those tasks which must be provided independently, such as bathing, dressing, ambulating, etc. For households in which there are two or more recipients receiving E&D Waiver services from the same provider, the amount of time for tasks which could and should be provided for both recipients simultaneously (such as meal preparation, cleaning rooms, laundry, and shopping) must be combined.

When two individuals who live in the same home request services, the following rules apply:

- Plans of care are to be developed separately for activities of daily living (ADLS), and each individual will receive the number of hours required for his or her plan of care;

- Time for instrumental activities of daily living (IADL) such as cooking, housekeeping, grocery shopping, etc., are to be combined and the hours split between the plans of care. For example, if it requires one hour to complete IADLs for both individuals, then 30 minutes will be added to each plan of care;

- Supervision hours are to be split between the plans of care unless there is justification for one-on-one supervision; and

- The recipients have the right to choose separate agencies to provide care. In this event, follow rules in 1 and 2 above.

Examples may include: (i) a husband and wife who require assistance with only their activities of daily living, but no supervision. (ii) three sisters, two of whom require assistance with their activities of daily living and one requires supervision. (iii) two recipients in the same home and one leaves for Adult Day Health Care after receiving assistance with activities of daily living, but the other remains in the home with supervision.

Recipients who reside in the same home are permitted to share their personal care service hours.

**SCHEDULED SERVICES NOT PROVIDED**

The personal/respite care aide is responsible for following the current plan of care as outlined in the DMAS-97A.

If services were not provided as scheduled, the provider may not add the unused hours to another day to "make up" the hours.

**LAPSE IN SERVICE - 30 DAYS OR MORE**

The provider must report to WVMI (by sending a DMAS-122) any recipient who, for any reason including hospitalization, does not receive services for 30 days or more. A copy of the DMAS-122 must be sent to the recipient's eligibility worker. A new screening is required for any recipient who has had a lapse in services for 180 days or more regardless of whether the recipient returns to the same provider or chooses to receive services from a different provider. A new screening is required if, during the lapse in services, the recipient entered a rehabilitation hospital, nursing facility, or Assisted Living Facility.

To re-enroll a recipient into waiver services after the recipient was closed to services within 180 days, the RN supervisor must:

1) Conduct a home visit to assess whether the recipient continues to meet waiver criteria. Document this information and submit this full assessment (DMAS-99) of the recipient's functional and medical status according to definitions and criteria in the "Exhibits" at the end of this chapter. Develop a new plan of care (DMAS-97A for Personal Care or DMAS-301 for ADHC) which shows the new effective date, and if the reassessment requires hours over his or her level of care or requires supervision time not in the plan of care, the RN supervisor must contact WVMI for approval; and

2) Submit a DMAS-122 to the local DSS indicating the date that services were

resumed.

If the RN supervisor or ADHC Coordinator/Director has any concerns that the recipient no longer meets the level of care criteria, the RN supervisor is advised to refer the recipient for a pre-admission screening.

If the recipient requests services from a new provider after a lapse in service which exceeds 180 days, a new pre-admission screening is required.

**REFUSAL OF PERSONAL/RESPITE CARE SERVICES BY THE RECIPIENT**

Recipients have the right to refuse services. This refusal must be documented by the aide on the aide's daily records. If all services for the day are refused, the aide should leave the home and document the early departure time. If services are refused frequently, a reduction in hours may be warranted (see "Decrease in Hours" in this chapter).

The provider may not bill Medicaid or the recipient for any time services are scheduled, but the aide is not able to provide care (e.g., the aide arrives and the recipient is not home).

**DEFINITION OF ADULT DAY HEALTH CARE SERVICES**

Adult Day Health Care Services (ADHC) in Virginia may be offered to elderly and physically disabled recipients who have been assessed to be at risk of institutionalization, meet the criteria for nursing facility care, and have been authorized for ADHC services by a Screening Team or by WVMI review analysts. ADHC services are defined as long-term maintenance or supportive services which are necessary in order to enable the recipient to remain at home rather than enter a nursing facility. ADHC can be offered only to recipients meeting nursing home pre-admission screening criteria (the same long-term care criteria as required for personal care and respite care admission) and for whom ADHC (either solely or in conjunction with personal care, respite care, and/or PERS) would be an appropriate alternative to institutional care.

ADHC services are designed to prevent institutionalization by providing recipients with health, maintenance, and rehabilitation services in a congregate daytime setting. The significant difference between ADHC and personal care is the congregate setting in which ADHC is rendered. DMAS will enter participation agreements with qualified adult day care centers which are licensed by the Virginia Department of Social Services (DSS) and which meet all DMAS provider standards to provide ADHC services to Medicaid-eligible recipients who have been authorized to receive ADHC.

ADHC services cannot be offered to recipients who are residents of intermediate care facilities, skilled care facilities, assisted living facilities, or adult foster homes licensed or certified by DSS.

The services offered by the ADHC Center must be designed to meet the needs of the individual recipient. Thus, the range of services provided by the ADHC Center to each recipient may vary to some degree. There must, however, be a minimum range of services available to every Medicaid ADHC recipient: nursing services, rehabilitation services

coordination, transportation, nutrition, social services, recreation, and socialization services.

DMAS will reimburse a per diem fee to any approved ADHC Center which has a participation agreement with DMAS (see Chapter V) which is considered payment in full for all services rendered to that recipient as a part of the recipient's approved adult day health care plan of care. A day is defined as attendance at the ADHC center for six hours or more.

Aide Responsibilities: The aide must provide assistance with activities of daily living (e.g., ambulating, transferring, toileting, eating or feeding, bathing, dressing), supervision of the recipient, and assistance with the management of the recipient's plan of care.

Nursing Responsibilities: These services include periodic evaluation of the nursing needs of each recipient; provision of the indicated nursing care and treatment; responsibility for monitoring, recording, and administering prescribed medications; supervising the recipient in self-administered medication; or general supervision of individuals who are certified in medication management and administering medications through the Board of Nursing.

Nursing functions also include the support of families in their home care efforts through education and counseling, and helping families identify and appropriately utilize health care resources.

Rehabilitation Services Coordination Responsibilities: These services are designed to ensure the recipient receives all rehabilitative services deemed necessary to improve or maintain independent functioning, to include the coordination and implementation of physical therapy, occupational therapy, and speech therapy. The Center may arrange for individual rehabilitation treatment with an outpatient facility or independent rehabilitation provider. The coordination and implementation responsibilities of the Center include:

- A referral for an evaluation by the appropriate rehabilitative discipline when necessary;
- Provision of rehabilitation therapy in the ADHC Center if the recipient chooses to receive rehabilitation services during ADHC. Reimbursement for rehabilitation services are not part of the reimbursement fee for ADHC; and
- Coordination of any resultant rehabilitative treatment plan into the recipient's overall plan of care to include arrangement of transportation from the ADHC center to the rehabilitation provider if necessary, and implementation by ADHC staff (designated by the Coordinator) of activities prescribed by the therapist in conjunction with ongoing therapy.

Transportation Responsibilities: Every DMAS-approved ADHC center must provide transportation when needed in emergency situations for any Medicaid recipient to and from his or her home (e.g., the primary caregiver has an accident and cannot transport the recipient home). Any ADHC center which is able to provide recipients with transportation

routinely to and from the center can be reimbursed by DMAS based on a per trip (to and from the recipient's residence) fee (see Chapter V). This reimbursement for transportation must be pre-authorized by either the Screening Team or the WVMI review staff.

Nutrition Responsibilities: The ADHC center must provide one meal per day which supplies one-third of the daily nutritional requirements. Special diets and counseling must be provided as necessary.

ADHC Coordination: The ADHC Coordinator, designated by the ADHC Director, must coordinate the implementation of the plan of care, make updates to the plan of care, record 30-day progress notes, and review the recipient's daily log each week (when the log is completed by a program aide). The designation of a professional staff member as the ADHC Coordinator is intended to promote the maintenance of the recipient's physical and mental health by coordinating services and providing assistance with any personal or social problems. This may be accomplished by individual or group discussion of problems, coordination with family, home, and other community agencies, counseling and referral to available community resources. In cases where the recipient only receives ADHC and PERS, the ADHC Coordinator is responsible for ensuring the continued appropriateness of PERS.

Recreation and Social Activities Responsibilities: The ADHC center must provide planned recreational and social activities suited to the needs of the recipients and designed to encourage physical exercise, prevent deterioration, and stimulate social interaction.

A multi-disciplinary approach to developing, implementing, and evaluating each recipient's plan of care is essential to quality ADHC services.

Skilled Services and ADHC

An ADHC center may choose to admit recipients who have skilled needs. Examples of the type of services requiring professional skills include the following: tube feedings, Foley catheter irrigations, sterile dressings, or any other procedures requiring sterile technique. ADHC center aides cannot perform these services. It is permissible, however, for a nurse to give skilled services at the same time that an ADHC aide is in attendance. A center can admit recipients who have skilled needs, only if there is professional nursing staff immediately available onsite to provide for the specialized nursing care required by these recipients.

ADHC services may take the place of personal care services either completely or for several days a week if it is determined that this would meet the needs of the recipient. ADHC augments the social support system available to the recipient by providing some assistance with activities of daily living and the intensive professional component of institutional care in a congregate daytime setting. A recipient may attend ADHC during the day and also receive personal care services in the morning or evening, or both, as appropriate to meet the identified needs.

## AUTHORIZATION FOR RECIPIENTS ALREADY ATTENDING ADULT DAY HEALTH CARE AS PRIVATE PAY OR GRANT-FUNDED

Recipients who are currently attending an ADHC center under a private pay or grant status, whose funding source has been exhausted, and who may be determined Medicaid eligible, may be eligible for ADHC services under the E&D Waiver. The ADHC center should contact the local Screening Team and arrange for a screening to be completed on the recipient in question. The Screening Team determines the recipient's status as a recipient in need of Medicaid-funded ADHC services. A request for a Pre-Admission Screening for nursing facility placement can be initiated by the recipient who desires the requested care, a family member, a physician, a local health department or social services professional, or any other concerned individual in the community.

## ADHC RESPONSE TO REFERRAL

The ADHC provider shall not begin services for which they expect Medicaid reimbursement until the admission packet is received from the Screening Team and not before the date authorized by the Screening Team on the DMAS-96. It is the responsibility of the provider to ensure that it receives a complete and correct screening packet prior to starting care.

The ADHC provider has the authority and responsibility to determine, prior to accepting the referral from the Screening Team, whether the provider can adequately provide services to the recipient. No referral should be accepted unless the provider has the staff capability and the recipient being referred appears appropriate for the provider's program. There may, however, be instances where the provider is unaware of a problem that will prohibit service delivery until the ADHC completes the initial assessment.

Upon receipt of the referral and no later than the recipient's fifth (5th) visit to the ADHC center, the plan of care must be developed based on the needs identified by the Screening Team and the ADHC professional staff's evaluation of the recipient's need for nursing, transportation, nutrition, social work, rehabilitative services, PERS and recreation services. The staff will meet to develop a plan of care for that recipient, using the ADHC Interdisciplinary Plan of Care (DMAS-301) to document the goals and objectives for each of the major areas of recipient needs. The DMAS-301 must include the recipient's name and Medicaid number, the ADHC provider identification number, signatures of the interdisciplinary team members present, the date services actually began, and the content of the plan of care. The DMAS-301 must also address all medications the recipient takes, not just those received at the center.

If, during the development of the interdisciplinary plan of care, the ADHC center evaluates the recipient's needs and develops a plan of care that involves a change to the number of days or hours of participation in ADHC from the days or hours authorized by the Screening Team, the ADHC center must contact WVMI to discuss a possible change in plan of care authorization. The ADHC provider must contact WVMI for preauthorization any time the number of days a recipient attends ADHC or the number of transportation trips provided by the center changes, including changes from the initial screening (DMAS-97) to the provider's start of services.

## RESPONSE TO INAPPROPRIATE AUTHORIZATION OF ADHC SERVICES

The ADHC should not initiate services if the ADHC professional staff determines one of the following during the initial assessment:

- the recipient is not appropriate due to health, safety, and welfare concerns;
- an appropriate plan of care cannot be developed to meet the recipient's needs;
- the recipient does not meet the criteria for the program; or
- the recipient does not meet the target population for the E&D Waiver.

If the ADHC determines that the ADHC should not initiate services, the ADHC must notify WVMI of this decision immediately. The provider is responsible for providing WVMI with the documentation supporting their decision. If WVMI agrees that the ADHC should not start services, WVMI must send a letter of notification to the recipient informing him or her of this and providing appeal rights.

The recipient will have 30 days to appeal the WVMI decision. Copies of WVMI's letter to the recipient will be sent to the provider and the Screening Team.

If WVMI disagrees with the ADHC's decision not to initiate care, WVMI will contact the ADHC in writing and inform them that services can be initiated.

If the ADHC does not initiate care because of the ADHC's inability to staff the case adequately, the provider must assist the recipient with locating another provider. If no provider is available in the community who could staff the case, the provider must inform the recipient of this in writing. ADHC providers should, however, explore the possibility of personal/respite care as an alternative if the recipient is appropriate and that service is available in the community.

## MONITORING THE RECIPIENT'S CONDITION AND CHANGES TO THE PLAN OF CARE FOR ADHC SERVICES

The ADHC provider must assess the recipient's functional and medical condition and record as necessary any changes to his or her condition in the 30-day progress note and quarterly on the DMAS-301. The provider must know the DMAS criteria for ADHC services and take action to modify the plan of care as needed to ensure that the days and type of care and services are appropriate to meet the current needs of the recipient. If the provider determines the recipient is no longer appropriate for attendance at the center, the provider may terminate the recipient from their center, but not from authorization for the waiver. It is the responsibility of the provider to notify WVMI when the provider believes the recipient no longer qualifies for services under the waiver. Only DMAS or WVMI may terminate the recipient from the waiver.

ADHC services may be authorized for up to seven (7) days of service and 14 trips per week based on the recipient's needs and the center's availability. Any time the number of days a

recipient attends day health care or the number of transportation trips provided by the center changes, the plan of care must be modified. The ADHC Coordinator must contact WVMI to ensure that the correct number of days is entered into the system to facilitate correct claims processing. The most recent plan of care must always be in the recipient's record.

## AUTHORIZATION FOR MEDICAID PAYMENT OF ADHC SERVICES

Screening and preauthorization of ADHC services by the Nursing Home Pre-Admission Screening Team is mandatory before Medicaid will assume payment responsibility for ADHC services.

Medicaid will not pay for any ADHC services delivered prior to the authorization date of the physician's signature on the DMAS-96 approved by the Nursing Home Pre-Admission Screening Team. The date of this authorization cannot be made prior to the date on which the assessment is completed and the Screening Team makes a decision.

Medicaid will assume payment responsibility for ADHC services only after the Department of Social Services has determined that the recipient is financially eligible for medical assistance for the dates services are to be provided.

If a recipient is receiving both personal care and ADHC services, the personal care provider is the primary provider and is responsible for the DMAS-122. Both service providers must notify each other, as well as WVMI, of any change, including termination of services, that occurs in the recipient's plan of care or provision of services via the DMAS-122.

## CHANGE IN SERVICES PROCEDURES FOR ADHC

Increase in Days of Service

WVMI must preauthorize any increase in days of service, either at the time of enrollment or afterward. The ADHC center must contact WVMI and provide the following information:

- The reason the increase in days of service is needed;
- The effective date of the increase;
- The recipient's Medicaid number; and
- Information regarding the recipient's functional and medical status, social support system, and other services the recipient receives.

(Note: If the recipient receives personal care under the E&D Waiver, the ADHC center must have the provider number of the personal care provider and must know how personal care services will be affected by the increase in the days of service.)

If WVMI approves the increase, verbal authorization will be given and the Community-Based Care Authorization Form will be sent to the ADHC provider. The ADHC will send a copy of this form to both the recipient and the personal care provider (if applicable.)

If the increase is denied, WVMI will indicate on the Community-Based Care Authorization Form that the increase was denied and the reason for the denial. WVMI will send this copy to the ADHC center. The ADHC center must send a copy of this form to the recipient. Recipients have the right to appeal any adverse action taken by WVMI.

WVMI will not retroactively approve increases.

Decrease in Days of Service (ADHC-Initiated Decrease)

- The ADHC center will send the recipient a letter giving the reason for the decrease, the effective date of the decrease, the recipient's Medicaid number, and the recipient's right to reconsideration.

- A copy of this letter will be sent to WVMI.

WVMI staff will enter increases and decreases of service into the computer. Once the entry has been made, the provider should receive a computer-generated letter informing the provider that the change was made and that the provider may now bill for the change in service.

It is not necessary for the ADHC to send WVMI the revised plan of care or supporting documentation unless this information is requested. Plans of care and the Community-Based Care Authorization forms must be maintained in the recipient's record. The plans of care and documentation of service delivery must be consistent with the information communicated to WVMI.

Analysts are available by telephone from 8:00 a.m. to 5:00 p.m. Monday through Friday to consider requests from providers for changes (increases or decreases) to existing authorizations, to provide technical assistance on policy issues, and to assist providers with problem-solving on recipient issues. All telephone calls will be returned by WVMI within one business day.

**ADHC PROVIDER DOCUMENTATION REQUIRED**

The ADHC center shall maintain all records of each ADHC recipient. These records shall be reviewed periodically by the DMAS staff. At a minimum, these records shall contain:

- The Uniform Assessment Instrument (UAI), the Consent for Exchange of Information (DMAS-20), the Nursing Home Pre-Admission Screening Authorization (DMAS-96), the Screening Team Plan of Care (DMAS-97), and the DMAS-101 (if applicable). Copies of these forms are in "Exhibits" at the end of this chapter.

- The Interdisciplinary Plan of Care (DMAS 301) developed by ADHC center professional staff. A copy of the ADHC Interdisciplinary Plan of Care is in "Exhibits" at the end of this chapter.

- At least every three months at an interdisciplinary staff meeting, the plan of care must be reviewed and updated. The initial ADHC plan of care can be used for documentation of interdisciplinary staff meetings and to make up to three updates to the plan of care as long as the recipient's status has not significantly changed. A new plan of care should be developed whenever re-evaluation indicates a need for significant changes to the plan of care.

- At a minimum, the individual designated as the ADHC Coordinator should record 30-day progress notes. If a recipient's condition and plan of care change more often, progress notes must be written more often than every 30 days. Progress notes must:

  1. Describe the recipient's medical and functional status;

  2. Note contacts made to or from the primary caregiver;

  3. Indicate any change in social supports;

  4. Indicate any other services received by the recipient; and

  5. Reference a review of the 30-day rehabilitative progress report and updated plan of care, if appropriate.

  DMAS does not require a form for recording the progress notes. However, the DMAS-99 form may be used for this purpose. At a minimum, the functional status section of the DMAS-99 form must be completed every 30 days by the RN or ADHC Coordinator.

- The ADHC center will obtain a rehabilitative progress report and updated treatment plan from any professional discipline involved in the recipient's care every 30 days (e.g., physical therapy, speech therapy, occupational therapy, etc.).

- Daily logs of service provided (DMAS-302) - The daily log must contain the specific services delivered by ADHC center staff. The log must also contain the arrival and departure time of the recipient and a weekly signature by an ADHC professional staff member. The daily log must be completed on a daily basis, not before or after the date of service delivery. At least once a week, a staff member must chart significant comments regarding care given to the recipient. The weekly comment section must be completed unless that information is contained elsewhere in the recipient's record. If the staff member writing comments is different from the staff member signing the weekly log, the commenting staff member must sign the weekly comments. Rubber-stamped signatures cannot be used.

- All correspondence to the recipient and to WVMI.
- All Plans of Care.

The provider must use the approved DMAS forms or exact duplicates, where indicated. These forms may be downloaded from the DMAS web site or may be copied from the Exhibits in this manual.

**LAPSE IN SERVICE OF 30 DAYS OR MORE FOR ADULT DAY HEALTH CARE RECIPIENTS**

The provider must report to WVMI (by sending a DMAS-122) any recipient who, for any reason including hospitalization, does not receive services for 30 days or more. A copy of the DMAS-122 must be sent to the recipient's eligibility worker. A new screening is required for any recipient who has had a lapse in services for 180 days or more regardless of whether the recipient returns to the same provider or chooses to receive services from a different provider. A new screening is required, if, during the lapse in services, the recipient entered a rehabilitation hospital, nursing facility, or Assisted Living Facility.

Recipients may resume ADHC services after a lapse of 30 days or more, if all of the following criteria are met:

1) The date of service resumption occurs within 180 days from the last date of service delivery;

2) The recipient has not entered an inpatient rehabilitation center or nursing facility, which includes inpatient units within a hospital setting, within that six-month period; and

3) The provider coordinator, director or RN supervisor is able to determine and document that the recipient continues to meet nursing facility criteria and requires ADHC in order to remain in the community.

To re-enroll the recipient into waiver services after the recipient was closed to services within 180 days, the ADHC coordinator or director must:

1) Conduct a thorough assessment to determine whether the recipient continues to meet waiver criteria. Document this information and submit to WVMI this full assessment of the recipient's functional and medical status according to the definitions and criteria (using the DMAS-99 form) and a plan of care (DMAS-301) which shows the new effective date; and

2) Submit a DMAS-122 to the local DSS indicating the date that services were resumed.

If the ADHC Coordinator/Director has any concerns that the recipient no longer meets the level of care criteria, he or she is advised to refer the recipient for a pre-admission screening.

If the recipient requests services from a new provider after a lapse in service which exceeds 180 days, a new pre-admission screening is required.

## REFUSAL OF ADULT DAY HEALTH CARE SERVICES BY THE RECIPIENT

Recipients have the right to refuse services. This refusal must be documented by the ADHC on the recipient's daily logs. If services are refused frequently, an interdisciplinary evaluation should be conducted, and WVMI staff should be contacted, if appropriate.

## PREAUTHORIZATION PROCESS

Preauthorization for Elderly & Disabled Waiver enrollments is conducted by WVMI, the DMAS contractor (effective April 2, 2001). WVMI will review all preauthorization requests, including new enrollments, re-enrollments, transfers, requests for additional services and telephonic inquiries. Providers will have the option of submitting all preauthorization requests to WVMI either telephonically, via facsimile, or by mail. Initial enrollments must be faxed or mailed. Any other requests may be received by telephone, fax, or mail. If necessary, WVMI will request additional documentation be submitted by fax or mail.

Telephonic Preauthorization

To initiate a telephonic request, providers call WVMI directly and provide the information requested by the analyst. While on the line, the analyst will approve, deny, or pend the request for additional information. Providers will know the status of the request before the call ends. All initial telephonic requests as well as any information submitted in response to pended letters, must be directed to WVMI. Additionally, the provider will need to verify that the required documentation and justification exists in accordance with federal and State regulations and DMAS published criteria, policy, and procedures. Fully completed plans of care and appropriate justification of services will be verified upon DMAS post payment review audit and may be requested by WVMI for preauthorization determination. In addition to verbal confirmation of the decision, WVMI will send a written validation that will include a 9-digit tracking number. WVMI can be contacted at

| | |
|---|---|
| (804) 648-3159 | Richmond |
| 1-800-299-9864 | All Other Areas |

Providers have the option of mailing or faxing requests as well. If a request is made for adding services to an existing recipient who has an immediate need (immediate need as identified as within 1-3 days from the request date) the provider is encouraged to initiate telephonic preauthorization. If the RN supervisor assesses the need for supervision time or hours over the level of care on the initial visit of a new enrollee, the request for preauthorization of supervision time should be made by telephone. The authorization may be approved, however this is dependent on the recipient meeting criteria for the waiver. A

tracking number will be assigned and given to the provider while on the line; this tracking number must be included with the submission of the new enrollment so that the authorization for supervision time will be included in the provider's preauthorization request for the new enrollment.

Facsimile Preauthorization Requests

To submit a request by facsimile, all necessary documentation must be sent with the completed Community Based Care Request for Services cover sheet, located at the end of this chapter under "Exhibits".

Fax requests to the following number:

| | |
|---|---|
| (804) 648-6992 | All Areas |
| 1-866-510-7074 | Toll Free |

Mail Preauthorization Requests

All initial enrollments must be mailed or faxed. To submit information via mail, complete the Community Based Care Request for Services cover sheet located at the end of this chapter under "Exhibits." Mail requests to the following address:

WVMI
Attn: CBC Review Unit
Bank of America Building-Suite 402
1111 East Main Street
Richmond, Virginia 23219

Information in response to a pend must be submitted to WVMI within 30 days. Failure to provide the requested information to WVMI will result in a reject or a denial of the request. If the request is rejected, an entirely new request must be submitted to WVMI.

Reconsiderations and Appeals

If the WVMI analyst denies services and the provider wants to request reconsideration of the denial, the provider must proceed with the following reconsideration process. If a telephonic request is denied, the provider may either request telephonic or written reconsideration from the WVMI Preauthorization Supervisor within 30 days of the date of the denial. The WVMI Preauthorization Supervisor has the option of requiring written reconsideration of a telephone preauthorization request. If a written request is denied, the provider must submit a letter to the WVMI Preauthorization Supervisor requesting reconsideration within 30 days of the notice.

Upon completion of the reconsideration process, the denial of services not yet rendered may be appealed in writing by the Medicaid recipient within 30 days of the written

notification of denial. If the denial is for a service that has already been rendered, the provider may appeal the adverse decision in writing within 30 days of the written notification of denial of the reconsideration. All written appeals must be addressed to:

Director, Appeals Division
Department of Medical Assistance Services
600 East Broad Street, Suite 1300
Richmond, Virginia 23219

Addition of ADHC as an Additional Service:

If a recipient has been screened and authorized to receive only personal/respite care and the need for ADHC as an additional home and community-based care service has been identified, the personal/respite care or ADHC provider must contact a WVMI review analyst to obtain authorization.

The WVMI review analyst will need the following information to complete this authorization:

- The reason ADHC services are being sought;
- The ADHC center the recipient will attend (including the center's Medicaid provider identification number);
- The start of care for attendance at the ADHC setting;
- The number of days per week a recipient will attend; and
- Whether transportation will be provided through the ADHC center.

The WVMI review analyst will then send a copy of the authorization letter to the requesting provider.

Addition of Personal/Respite Care as an Additional Service

If the recipient has been screened and approved to receive ADHC and the need for personal care has been identified after ADHC has been initiated, the ADHC or personal care provider must contact the WVMI review analyst for authorization of personal care. ADHC would then become the secondary program. WVMI will conduct an assessment of the need for the additional Community-Based Care Service (personal or respite care), and if appropriate will authorize the additional service.

The WVMI review analyst will need the following information to complete this authorization:

- The anticipated provider of personal/respite care services (including the Medicaid provider identification number);

- The anticipated start date for personal/respite care services; and
- The estimated number of hours and times the personal/respite care is needed.

When the need for episodic respite care as an additional E&D Waiver service has been identified (according to the criteria above), the provider of the initial E&D Waiver service must contact WVMI. WVMI will conduct an assessment of the recipient's caregiver's need for respite care and, if appropriate, authorize respite care. It is at the discretion of WVMI's review analyst whether documentation will need to be submitted from the provider.

The admitting provider must send an enrollment packet to WVMI for a recipient who has been transferred from one provider to another. This enrollment packet consists only of the Provider Plan of Care (DMAS-97A) and a letter from the admitting provider identifying the provider transferring the case, identifying the last date of service rendered, and the reason for any changes made by the admitting provider to the recipient's plan of care. In addition, if the recipient had an authorization for respite care with the transferring provider, the number of hours used by that provider must be submitted to WVMI and the remaining balance of respite hours will be approved for the accepting provider.

**CHANGE IN SERVICES BY THE PROVIDER - ADVANCE NOTICE REQUIRED FOR PERSONAL/RESPITE/ADHC/PERS**

There are various financial, social, and health factors which might cause a provider to decide to terminate, increase, or decrease services to a Medicaid recipient. The provider must make adjustments to services as indicated by any change in the recipient's needs or situation. The provider must give the recipient or family 10 days' written notification of any decision to terminate or to change the amount of services received (unless the recipient requests a date which is less than 10 days and the provider documents the recipient's request).

<u>Decrease in Hours</u>

If the RN supervisor has determined that a decrease in hours of service is warranted, the RN supervisor must discuss the decrease in hours with the recipient or family during a home visit and document the visit and conversation in the recipient's record. If there is to be a decrease in hours, the provider must develop a new plan of care and notify the recipient, the caregiver, and WVMI. The provider must state in writing the specific reasons for the decrease, the new number of hours to be provided per week, and the effective date of the decrease in hours (10-day notification is required). A copy of this letter must be filed in the recipient's record. The provider must also send the recipient a copy of the revised DMAS 97-A. The letter must include the right to reconsideration statement as outlined later in this chapter. WVMI must also receive the new DMAS-97A and a copy of the recipient letter. If the recipient disagrees with the proposed decrease, WVMI shall be notified, and WVMI will conduct a review of the recipient service needs. This review will be completed within 10 working days from the date the request for reconsideration is received. The recipient or family and the provider will be notified in writing of the WVMI decision. The WVMI notification of the reconsideration decision

will contain the recipient's right to formally appeal the decision by notifying the Appeals Division at the Department of Medical Assistance Services. The provider must develop the new plan of care (DMAS-97A) and notify the recipient or family by letter if the decision by WVMI is to uphold or reverse the provider decision.

If the recipient requests a decrease in hours by telephone, the RN supervisor is not required to make an extra visit to the recipient's home. The RN supervisor will send a letter confirming the recipient's request, the new number of hours, and the effective date of the change. A copy of this letter must be sent to WVMI.

Increase in Hours

The provider is able to establish the amount of service in the plan of care, which is appropriate to meet the recipient's needs as long as the maximum number of hours per week for that recipient's level of care is not exceeded. (Under no circumstances can the recipient receive more hours of care than his or her level of care allows without prior approval from WVMI). The provider must telephone a WVMI review analyst to authorize the increase if a change in the recipient's condition (physical, mental, or social) indicates that either (i) supervision needs to be added to the plan of care or (ii) the recipient's level of care has changed and an increase to the plan of care is needed for more than the amount allowed according to the recipient's current level of care. This telephone contact must be documented in the recipient's record along with the date and time of the call, to whom the RN supervisor spoke, the requested information, and the outcome of the call. The updated DMAS-97A and any other documentation necessary to justify the need for and use of hours may be requested by the WVMI analyst

The WVMI analyst will send the provider a letter detailing the approval or denial of this request. This WVMI approval letter must be filed in the recipient's record. The provider must send a copy of this letter to the recipient or family. The recipient has the right to appeal any decision made by WVMI.

Termination of Services

The provider is expected to notify WVMI that termination is needed at any time the provider determines that a recipient does not have functional dependencies and medical or nursing needs that meet the criteria for personal/respite/ADHC/PERS, or that there are health, safety, or welfare issues which present an actual threat to the recipient.

The provider must notify WVMI immediately and submit documentation to WVMI, which supports the requested reason for termination. If WVMI agrees with the provider's recommendation, WVMI will terminate the recipient from the waiver. WVMI must send a decision letter to the recipient, which contains the right to appeal. If the recipient wishes to appeal the decision, the recipient must request an appeal, in writing, within 30 days of the notification of termination. If a request for appeal is filed before the effective date of this action, services may continue unchanged during the reconsideration process. The hearing officer will notify the provider if services are to continue.

The decision letter will contain the recipient's right to formally appeal the decision by notifying the Appeals Division at DMAS.

NOTE: Failure to notify WVMI within 30 days that a recipient does not meet level of care criteria could result in a retraction of payments. If WVMI disagrees with the provider, the provider may terminate its services to the recipient, but the recipient will remain open and eligible for the services from any other enrolled personal/respite/ADHC/PERS provider.

If the recipient agrees to termination of services by the provider, WVMI must send a letter to the recipient informing him or her of the reason for termination, the fact that the recipient agreed with the decision, and the effective date of the termination (which can be within 10 working days unless otherwise requested by the recipient). The letter must give the recipient the right to appeal. The provider must send a Patient Information Form (DMAS-122) to WVMI and a copy to the appropriate local DSS to notify DSS of the termination date.

If a recipient's care was terminated prior to his or her request for reconsideration and WVMI decides to reinstate services, the provider must send a copy of the WVMI letter reinstating services, along with a DMAS-122 to DSS. The DMAS-122 must note the date of termination as the last date of services rendered. In the event that a recipient's care was terminated prior to his or her request for reconsideration and the analyst decides to reinstate services, the provider must send a copy of the analyst's letter reinstating services, along with a DMAS-122, to the local Department of Social Services. The provider must make a reasonable effort to ensure continuity and appropriateness of care through referrals to any other appropriate sources of assistance.

Right to Reconsideration Statement

The provider must include the following statement in every decision letter related to a change in the number of service hours or days:

"You may request reconsideration of this decision by notifying, in writing, CBC Review Unit Supervisor, WVMI, Bank of America Building, Suite 402, 1111 E. Main Street, Richmond, Virginia 23219. This written request for a reconsideration must be filed within thirty (30) days of this notification. If you file a request for reconsideration before the effective date of this action, (date), services may continue unchanged during the reconsideration process."

When WVMI receives a request for reconsideration, a preliminary evaluation will be completed within 10 working days from the date the request for reconsideration is received. This preliminary evaluation will consist of a telephone contact to review with the provider staff and the recipient or family the circumstances that created the adverse action to determine whether anything has been overlooked or whether there has been any change which might invalidate the adverse action decision. If it appears that something has been overlooked or there has been a change, WVMI may reverse the action taken by the provider. WVMI will notify the recipient, in writing, of the decision and also provide the provider with a copy of the letter. The WVMI notification of the reconsideration decision

will contain the recipient's right to formally appeal the denial decision by notifying the Appeals Division at DMAS.

Providers may terminate services to individuals who are receiving personal/respite/ADHC/PERS services if the provider can no longer staff the case. If the recipient chooses to remain with the current provider while the provider attempts to hire more staff, the recipient must be informed of progress or lack of progress and alternatives. The provider must inform the recipient that if services are not received for 30 days his or her Medicaid eligibility could be affected. The provider must also inform the recipient if services are not received for 180 days that a new screening must be completed by the local Screening Team.

The regulations state that providers may terminate services to a recipient after giving the recipient or family five days' written notification of the intent to terminate services. The letter shall provide the reasons for and the effective date of the termination (which shall be at least five days from the date of this notification). This notice must not contain appeal rights since the recipient has not been terminated from Medicaid services.

**CHANGE IN SERVICES BY THE PERSONAL/RESPITE/ADHC/PERS PROVIDER-ADVANCE NOTICE NOT REQUIRED**

Personal/Respite/ADHC/PERS services may be terminated immediately by WVMI, without prior notice, if the provider's staff is in immediate danger, the recipient requests immediate termination of services, or the provider does not have staff available to render care and is unable to secure a substitute aide or transfer services. If the provider does not have staff, the provider must attempt to transfer services to another provider. If the recipient has adequate back-up support and requests that the provider not transfer the case, the provider may terminate the recipient from its services. However, WVMI must be notified first with supporting documentation; then the provider will send a letter to the recipient indicating that the provider must terminate services. A copy of this letter must go to WVMI, Department of Social Services, and Adult Protective Services if applicable.

A change in services by the provider does not include those situations in which the provider has some concerns about the recipient's health and safety. In these situations, the provider must detail to the WVMI review analyst the concerns and continue to provide services pending a decision by the analyst regarding the recipient's continued appropriateness for waiver services.

When the provider determines that the recipient or the recipient's environment presents an immediate danger to personnel, WVMI must be notified immediately by telephone, with a follow-up in writing from the provider. The provider will issue a termination letter to the recipient stating that services will be or have been terminated. This letter from the provider must state the effective date of termination and an accurate statement regarding the reason for termination. This letter must provide the recipient with the address and telephone number for WVMI. The WVMI review analyst will promptly evaluate the situation and determine whether services continue to be appropriate. If WVMI decides that services continue to be appropriate, WVMI will advise the recipient to contact another approved personal/respite/ADHC/PERS provider for continued services. A copy of the letter must

be filed in the recipient's record and a copy of the letter with a DMAS-122 (Patient Information form) must be sent to the CBC Review Unit of WVMI. A copy of the DMAS-122 must be sent to the appropriate local DSS, giving the termination date as the last date of service rendered.

If a recipient's services were terminated, either due to a lack of staffing, immediate danger to agency personnel, or due to the recipient's failure to pay the patient pay amount, the provider's letter should not give the recipient the right to reconsideration.

If a provider terminates a recipient from services, the provider must send a letter to the recipient stating that services will be or have been terminated. This letter must state the effective date of termination and an accurate statement regarding the reason for termination. This letter must provide the recipient with the address and telephone number for WVMI. The WVMI review analyst will promptly evaluate the situation and determine whether services continue to be appropriate. If WVMI decides that services continue to be appropriate, WVMI will advise the recipient to contact another approved provider for continued services. A copy of the letter must be filed in the recipient's record, and a copy of the letter with a DMAS-122 (Patient Information form) must be sent to the CBC Review Unit at WVMI. A copy of the DMAS-122 must be sent to the appropriate local DSS, giving the termination date as the last date of service rendered.

**SUBMISSION OF TRANSFER ENROLLMENT PACKAGES FOR PERSONAL/RESPITE, ADULT DAY HEALTH CARE SERVICES OR PERS SERVICES**

For a transfer admission, the new provider must send to WVMI the DMAS-97A or DMAS-301, the DMAS-122, or a transferring letter from the previous provider indicating the last billable date of service, and the DMAS-100 (if the plan of care includes supervision time). NOTE: If the lapse in time between services is more than 180 days, the recipient must be re-screened by the local Screening Team.

If the recipient's previous plan of care included supervision or was for hours over the recipient's level of care and the new (receiving) provider has evaluated and found that these same hours are needed; the new provider should call the review analyst at WVMI to verify authorization of these hours that were previously approved, or to obtain authorization if they were not previously approved. If the new provider's plan of care is a decrease in hours from what the recipient was previously receiving, the provider must send the recipient a decrease notification letter giving the right to reconsideration. These decreased hours may be implemented if the recipient is in agreement with the new hours and plan of care. If the recipient disagrees with the decrease and the new plan of care, the hours must remain the same until review of the reconsideration by a WVMI supervisor. WVMI will notify the recipient and the provider of its decision.

**TRANSFER FROM MANAGED CARE TO COMMUNITY BASED CARE**

Effective July 1, 1995, DMAS began assignment of the elderly and disabled populations into managed care programs. However, nursing facility and community-based care waiver recipients are excluded from assignment to a managed care program. Exclusion will occur

once the recipient is enrolled in the Medicaid Management Information System under the Elderly & Disabled Waiver.

In the event that a Medicaid-eligible recipient who is enrolled in a managed care program is admitted to a nursing facility or community-based care program, the long-term care provider will not be able to bill for long-term care services until the recipient is disenrolled from the managed care program. To accurately exempt long-term care recipients from assignment to a managed care program, DMAS must have an accurate reporting of who is in a nursing facility or community-based care program. DMAS identifies that a Medicaid-eligible person is in a nursing facility or community-based care waiver when the provider sends the enrollment package.

In some instances, the provider may accept a referral and start care when the recipient's Medicaid eligibility is in a pended status. In these instances, continue to hold the enrollment package until obtaining a valid Medicaid number. Submit the admission documents immediately upon notification of Medicaid eligibility. If there is difficulty confirming the person's eligibility status, contact the eligibility worker's supervisor in the local agency and, if that person is unable to resolve the questions, contact the regional eligibility specialist.

Do not include any other correspondence or invoices in the enrollment packet**.** The WVMI analyst will ensure the accuracy of all forms submitted for recipient enrollment, and that level of care criteria and the appropriateness of E&D Waiver services have been met. Any packet, which is incomplete or submitted incorrectly, will be pended by WVMI, and the provider will be notified. Do not submit the enrollment package without a Medicaid number for the recipient.

A computer-generated letter ("blue letter") will be sent to the provider confirming that the provider may now bill for services. The approved number of hours entered is from the provider Plan of Care (DMAS-97A). If the provider does not receive this letter within 60 days, the provider should contact the Provider HELPLINE at 1-800-556-8627 to check on the status of the enrollment. If the HELPLINE confirms that the recipient is enrolled, the provider must document in the recipient's record: the time and date, the DMAS representative to whom they talked, and the information given about the enrollment. The "blue" letter is not a part of a provider's required documentation, and one cannot be duplicated. If a provider has not received one on a recipient but the HELPLINE has confirmed the enrollment, the provider should not call WVMI to request a copy.

**IN-PATIENT REHABILITATION FACILITY TO PERSONAL/RESPITE CARE/ADULT DAY HEALTH CARE**

Once a recipient has been admitted to a rehabilitation facility, regardless of the length of stay, a new pre-admission screening is required prior to readmission to community-based care services. The pre-screening for inpatient rehabilitation admissions shall be completed at the rehabilitation facility by a contract screening team. Since many hospitals have rehabilitation units connected to the hospital, it is important to check with the hospitals to confirm whether the recipient has been in the acute care portion of the facility prior to

resuming waiver services. Services provided after a stay in a rehabilitation facility without a new screening will not be reimbursed by DMAS.

**E&D WAIVER TO NURSING FACILITY TRANSFERS**

The additional information to be submitted to DMAS must include the UAI (Virginia Uniform Assessment Instrument); a cover letter, and Consent to Exchange Information Form (DMAS-20). This is completed by the provider. A Level II assessment is also required for recipients having a Mental Illness, Mental Retardation, or Related Condition (MI/MR/RC) diagnosis. The Level II is an additional assessment procedure, which requires the assessment and authorization from the Department of Mental Health, Mental Retardation, and Substance Abuse Services. Consequently, these screenings require an extended period of time for completion. It is vital that a diagnosis of MI/MR/RC be specifically noted in the accompanying letter when the screening request for nursing facility placement is submitted. The Level II screening must be completed prior to admission for all persons with a diagnosis or history of mental illness, mental retardation, or related conditions.

A UAI must be completed for this screening if one has not previously been done for the recipient in question. The current UAI may be updated and a copy, not the original, sent to DMAS with the following information:

- provide the Social Security Number, birth date, and current correct address, including the Zip Code, for this recipient;
- make sure that this information is legible and complete. (The original approval letter is sent to the recipient's address from the DMAS office.); and
- all information pertaining to functional needs, medical/nursing needs, medications, and orientation (pages 4, 5, 7, and 12) must be updated as indicated with the date of the reassessment. If no changes have occurred since the completion of the original UAI, a comment to this effect must be noted and dated.

The accompanying cover letter must include the following information:

- why the recipient is currently appropriate for nursing facility placement rather than continuing in community-based care; and
- a brief summary of the recipient's medical/nursing needs, including the diagnosis and any conditions requiring specific medical attention.

Submit the information for these screening reviews to:

Facility and Home Based Services Unit
Department of Medical Assistance Services
600 East Broad Street, Suite 1300
Richmond, Virginia 23219

- Do not send these screenings into the DMAS office or to WVMI in enrollment envelopes or with enrollment packets. If the screening information has been faxed in, no hard copies are needed.

- The DMAS decision letter, the new DMAS-96, and the MI/MR form will be mailed directly to the requesting CBC provider. The provider requesting the pre-screening must supply the updated UAI and any additional screening materials needed by the nursing facility to that facility. In some situations, where beds are waiting, verbal approval may be given by DMAS prior to the faxing of the approval letter. This is done by telephone directly to the nursing facility.

Nursing facility pre-screenings should be submitted to the DMAS office as soon as the placement is anticipated rather than waiting until a bed is available. If a bed becomes available unexpectedly, DMAS must be apprised of the bed waiting status in order for the review to be expedited.

Approvals

Nursing Facility Screening approvals completed by DMAS are valid for 12 months from the date of the approval letter. However, approvals older than 180 days must be updated with an addendum letter specifying that the condition of the recipient has remained the same or has deteriorated since the time of the reassessment. If the screening is older than 12 months, a new screening must be completed before services can begin. If the recipient's condition significantly improves, contact the DMAS Facility and Home Based Services Unit at (804) 225-4222 for further instructions.

If nursing home placement is authorized, and E&D Waiver services are terminated, the provider must notify (via a DMAS-122) the local DSS and WVMI of the date on which services were terminated. This date should be the last day of aide service in the home, or the last day the recipient attended ADHC.

## PROVIDER-TO-PROVIDER TRANSFERS

If a recipient transfers from one provider to another, the transferring provider will send the following to the new provider:

- originals of the UAI, DMAS-96, DMAS-97, DMAS-300 (for respite only) and the most current plan of care: DMAS-97A for personal/respite care, DMAS-301 for ADHC, and DMAS-100A for PERS;

- a current DMAS-122;

- the most recent review analyst's authorization letter (if hours exceed the maximum for the recipient's level of care);

- copies of chart entries pertaining to the recipient's history and current status;
- a statement or copy of the letter to the recipient giving the date the transferring provider is ending services and the reason for transfer; and
- respite **[balance]** if previously authorized and provided.

The transferring provider must retain a copy of any material sent to the receiving provider. The receiving provider's RN supervisor must visit the recipient prior to the start of care, develop a new provider plan of care, and send a copy to the WVMI CBC Review Unit indicating the name of the original provider and the last date of service provided by the original provider, the name of the provider receiving the transfer, and the effective date of the new provider's plan of care. The receiving provider must also send a DMAS-122 to the local DSS to inform them that a change in provider has occurred.

If the hours in the plan of care developed by the receiving provider exceed the previously developed plan of care, an explanation must be provided. The transferring provider must let the new provider know if a new screening is needed. If the hours needed exceed the recipient's level of care and were not authorized by WVMI while at the previous provider, the receiving provider must contact WVMI by telephone to obtain authorization for the hours prior to the provision of those hours. It cannot be assumed that a previous provider had the hours approved by WVMI just because the previous provider's plan of care was made out for that number of hours. If a recipient also had respite care authorized at the previous provider, the transferring provider must send verification of the respite dates (year) and number of hours used to the new provider. When a recipient is transferred from one provider to another, the last date of service at the original provider and the first date of service at the new provider cannot overlap.

Providers are strongly encouraged to submit their enrollment forms to WVMI within five (5) days of the Medicaid recipient's start of care with that provider. Recipients will not be enrolled if the enrollment date is over one (1) year old.

**TERMINATION OF E&D WAIVER SERVICES BY WVMI**

WVMI may terminate E&D Waiver services for any of the reasons stated below or for any other reason which might apply:

- E&D Waiver services are not the critical alternative to prevent or delay institutional placement;
- the recipient no longer meets community-based care criteria;
- the recipient's home does not provide for the recipient's health, safety, and welfare; or
- an appropriate and cost-effective E&D Waiver plan of care cannot be developed.

If the provider determines that any of these reasons for termination exist, the provider must notify WVMI by contacting the CBC Review Unit. The WVMI analyst will request that the provider submit documentation to support this determination.

The provider and the recipient will be notified in writing if personal/respite/ADHC services are to be terminated. The effective date of termination will be at least 10 days from the date of the termination notification letter. The provider will receive a copy of the decision letter sent to the recipient. The recipient has the right to appeal any action taken by WVMI to terminate services. An appeal filed by the recipient prior to the date of termination may entitle the recipient to continued services during the appeal process. However, if the WVMI decision is upheld by the Appeals Division at DMAS, the recipient may be required to reimburse Medicaid for all services received following the original date of termination. The provider will be notified in the event of an appeal and advised as to whether to continue previous services and bill Medicaid during the appeal process.

If the recipient elects to continue services during the appeal, and makes a request for any additional service (for example: respite or adult day health care) while the case is on appeal, each request will be acted upon separately by WVMI. If additional services are denied, the recipient will be given the right to appeal the denial of any request.

**PERSONAL EMERGENCY RESPONSE SYSTEMS (PERS)**

Definition

Personal Emergency Response System (PERS) is an electronic device that enables certain recipients at high risk of institutionalization to secure help in an emergency. PERS electronically monitors recipient safety in the home and provides access to emergency crisis intervention for medical or environmental emergencies through the provision of a two-way voice communication system that dials a 24-hour response or monitoring center upon activation and via the recipient's home telephone line.

DMAS will only reimburse services as defined in the service description, and that are within the scope of practice of the providers performing the service.

Criteria

PERS services are limited to those recipients, ages 14 and older, who live alone or who are alone for significant parts of the date, have no regular caregiver for extended periods of time and would otherwise require extensive routine supervision. Recipients must be receiving PERS services and another E&D Waiver service simultaneously.

PERS can be authorized when there is no one else other than the recipient in the home who is also competent and continuously available to call for help in an emergency. If the recipient's caregiver has a business in the home, such as a day care center, PERS will only be approved if the recipient is evaluated as being dependant in the category of "behavior patterns and orientation" on the Uniform Assessment Instrument.

Service Units and Service Limitations

A unit of service shall include administrative costs, time, labor and supplies associated with the installation, maintenance and monitoring of the PERS. A unit of service is one month rental price set by DMAS. The one-time installation of the unit includes installation, account activation, recipient and caregiver instruction and removal of equipment. The PERS provider must properly install all PERS equipment into a PERS recipient's functioning telephone line within 7 days of the request unless there is appropriate documentation of why this time frame could not be met.

PERS services shall be capable of being activated by a remote wireless device and be connected to the individual's telephone line. The PERS console unit must provide hands free voice-to-voice communication with the response center. The activating device shall be waterproof, shall automatically transmit, to the response center, an activator low battery alert signal prior to the battery losing power, and be able to be worn by the individual.

In cases where medication monitoring units must be filled by the provider, the person filling the unit must be a Registered Nurse or a Licensed Practical Nurse. The units can be refilled every 14 days.

The PERS provider is prohibited from performing all types of direct marketing activities to Medicaid recipients. Direct marketing means either (1) conducting directly or indirectly door-to-door, telephonic or other "cold call" marketing of services at residences and provider sites;(2) mailing directly;(3) paying "finders fees; (4) offering financial incentives, rewards, gifts or special opportunities to eligible recipients as inducements to use their services; (5) continuous, periodic marketing activities to the same prospective recipient, e.g., monthly, quarterly or annual giveaways, as inducements to use their services; or (6) engaging in marketing activities that offer potential customer rebates or discounts in conjunction with the use of their services or other benefits as a means of influencing recipients' use of provider's services.

Provider Documentation Requirements

1. A PERS provider must maintain a data record for each recipient utilizing PERS at no additional cost to DMAS. The record must document all of the following:

    - Delivery date and installation date of the PERS;
    - Enrollee/caregiver signature verifying receipt of PERS device;
    - Verification by a test that the PERS device is operational, monthly or more frequently as needed;
    - Updated and current recipient responder and contact information, as provided by the individual or the recipient's care provider; and

- A case log documenting recipient system utilization and recipient or responder contacts and communications.

4. The PERS provider must document and furnish a written respect for each emergency signal that results in action being taken on behalf of the recipient. This excludes test signals or activations made in error. This written **[request]** must be furnished to the personal care provider, or in cases where the recipient only receives ADHC services, to the ADHC provider. This information must be maintained in the recipient's record at the PERS provider agency.

5. The PERS provider must retain a copy of the DMAS-100A in the patient records. (See the "Exhibits" section for a copy of the form DMAS-100A).

## EXHIBITS

6802 Paragon Place II
Suite 410
Richmond, Virginia 23230
Ph: 1-804-648-3159
Toll Free: 1-800-299-9864

COMMUNITY BASED CARE
**REQUEST FOR SERVICES FORM**

Fax: 1-804-648-6992
Toll Free: 1-866-510-7074

___ New Request
**___ Pend Response**
**___ Change to Approval –Must include PA# on this form.**
**PA #** _____

Recipient Medicaid #_____ Name: (last)_____(first)_____

Recipient Phone # (Attendant Care and Consumer Directed Respite Only) (_____)_____-_____SS# _____-_____-_____ DOB: _____/_____/_____

Provider #_____ Provider Name: _____ Waiver: _____

Contact Person: _____ Phone #_____ _____ Fax: _____

Request Information:

| Provider Number | Provider Name | National Code | Type | Units | Effective Date |
|---|---|---|---|---|---|
| | | | | | ___/___/_____ |
| | | | | | ___/___/_____ |
| | | | | | ___/___/____ |
| | | | | | ___/___/____ |

WVMI Use Only:

| Hours | Effective Date | Status | PA # |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |

WVMI Use:
Date / Reviewer
___/___/____ / _____
___/___/____ / _____
___/___/____ / _____
___/___/____ / _____

Any pended preauthorization request cannot be processed due to missing, incomplete or illegible information. **WVMI Tracking Number:** _____
Please attach *only* the requested information to WVMI within 30 days. This does not require resubmission of the entire package.
Any rejected preauthorization request requires re-submission of the entire request package.

**Provider Comments:**

**WVMI Comments**:

**INSTRUCTIONS FOR COMPLETION OF THE WVMI REQUEST FOR SERVICES FORM**

This form is intended to summarize the services requested on the screening forms and must be completed when submitting requests to WVMI by facsimile or mail.

**Demographic Information:**

Recipient Medicaid #: Enter 12-digit recipient ID number
Name: Complete recipient name as it appears on the Medicaid card
Recipient phone number is required for CD PAS recipients
Recipient Social Security Number
DOB: Enter the recipient date of birth.
Waiver: Enter name of Waiver enrolled.
Provider #: Enter 9-digit provider number
Provider Name: Enter name of provider of services being requested
Contact Person: Enter provider agency name to contact for further information
Phone/Fax Numbers: Enter number with area code
PA #: Enter Prior authorization number you wish to make changes to

**Request Information:**

Provider #: Enter 9-digit provider number for Respite Care, CD Respite Care, NS and PERS.
Provider Name: Enter name of provider of services being requested
National Codes: Enter the national code for services requested. The following abbreviations may be used:

**E&D Waiver**:

| | |
|---|---|
| **S5102** | Adult Day Health Care |
| **S5160** | PERS Installation |
| **S5161** | PERS Monitoring |
| **S5160 U1** | PERS Med Monitoring/ Installation |
| **T1019** | Personal Care |
| **T1005** | Respite Care/aide |
| **S9125 TE** | Respite Care/ LPN |
| **S5185** | PERS & Med Monitoring |
| **H2021 TD** | PERS Nursing/RN |
| **H2021 TE** | PERS Nursing/LPN |

**AIDS Waiver:**

| | |
|---|---|
| **T1016** | Case Management |
| **T1005** | Respite Care/Aide |
| **T1002** | Private Duty Nursing/ RN |
| **T1003** | Private Duty Nursing LPN |
| **T1019** | Personal Care |
| **S9125 TD** | Respite Care RN |
| **S9125 TE** | Respite Care/ LPN |
| **S5126** | CD Attendant Care |
| **S5150** | CD Respite |
| **B4154** | Nutritional Supplement |

**CD PAS Waiver**

| | |
|---|---|
| **S5126** | Attendant Care |

**Elderly Case Management**

| | |
|---|---|
| **T1016** | **Elderly Case Management** |

**Type**: Complete type of request by indicating the letter for the corresponding services
E: Enrollment I: Increase D: Decrease T: Transfer D/C: Discharge
**Units/Hours**: Complete hours for the services being requested
**Effective Dates**: Complete the effective date for services requested.

# ADULT DAY HEALTH CARE DAILY LOG

**Recipient's Name**_____ **Medicaid #**_____

| | MON | TUES | WED | THUR | FRI | SAT | SUN |
|---|---|---|---|---|---|---|---|
| **Date (Month/Day/Year)** | | | | | | | |
| **ACTIVITY:** **Toileting** | | | | | | | |
| **Ambulation/Transfer** | | | | | | | |
| **Eating/Feeding** | | | | | | | |
| **Supervision** | | | | | | | |
| **Meals/Snacks** | | | | | | | |
| **Administer Medications** | | | | | | | |
| **Health Monitoring** | | | | | | | |
| **Skilled Services** | | | | | | | |
| **Social/Rec. Activities** | | | | | | | |
| **Transportation** | | | | | | | |
| | | | | | | | |
| **TIME IN** | | | | | | | |
| **TIME OUT** | | | | | | | |
| **NUMBER OF HOURS** | | | | | | | |

**WEEKLY COMMENTS:**_____ **DATE:**_____

| |
|---|
| |
| |
| |
| |
| |
| |

**WEEKLY SIGNATURES:**

**Recipient/Family Signature**_____ **Date:**_____

**ADHC Staff Signature**_____ **Date:**_____

**ADULT DAY HEALTH CARE INTERDISCIPLINARY PLAN OF CARE**

Participant _____ Medicaid # _____ ADHC Case Manager _____

**SERVICE PROVISION**

1. **ADL's – FOR EACH CATEGORY SPECIFY TYPE OF ASSISTANCE AND FREQUENCY**
   Toileting _____ Eating/Feeding _____
   Transfer _____ Supervision _____
   Ambulation _____

2. **NUTRITION**
   Meals/Snacks (specify frequency, type, special diet, allergy, etc.)_____
   _____
   Nutritional Counseling _____

3. **NURSING**

| Medication | Frequency | Doctor/Date | Medication | Frequency | Doctor/Date |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

   Health Monitoring (weight, vital signs, fluids, etc.) _____
   _____
   Skilled Services _____

4. **SOCIALIZATION/RECREATION**
   Counseling With Participant/Family (specify subject, participants, etc.) _____
   _____
   Recreational Restrictions _____
   Socialization Needs _____

5. **REHABILITATION**
   Therapies (specify type, frequency, & provider)_____
   _____
   Prescribed Supportive Activities (assistance with PT, OT, Speech home programs) _____
   _____

6. **TRANSPORTATION**
   Needs and Providers _____
   Emergency Transportation Plan _____

7. **CASE MANAGEMENT**
   Participant's primary Caregiver _____Phone _____
   Participant's Primary Physician _____Phone _____
   Other Service Providers _____
   _____

Date_____ Staff Present_____

**PLAN OF CARE UPDATES/INTERDISCIPLINARY STAFF MEETINGS (ALL STAFF INITIAL THEIR ENTRIES)**

Date_____ Evaluation/Comments_____
_____
Date_____ Evaluation/Comments_____
_____
Date_____ Evaluation/Comments_____
_____

| Initial | Identifies | Initial | Identifies | Initial | Identifies |
|---|---|---|---|---|---|
| | | | | | |

**IMAS 301 Rev. 7/90**

## MI/MR LEVEL I SUPPLEMENT FOR ELDERLY & DISABLED WAIVER APPLICANTS

**A. This section is to be completed by the Nursing Home Preadmission Screening Committee for individuals with MI and/or MR diagnoses seeking services under the Elderly and Disabled waiver.**

Name: _____ Date of Birth: _____ Date NHPAS Request Received: _____
Social Security Number: _____ Medicaid Number: _____ Responsible CSB: _____

**1. DOES THE INDIVIDUAL MEET NURSING FACILITY CRITERIA?** ___ Yes ___ No (Check "yes" only if both a and b below are answered "yes")

a. Does the individual meet the program criteria for the Elderly & Disabled Waiver AND is the individual at imminent risk? __ Yes ___ No
b. Can a safe and appropriate plan of care be developed to meet all medical/nursing/custodial care needs? ___ Yes ___ No

(If "yes", this form must be completed. If "no", do not complete Level I screening and do not refer for assessment of active tx needs. Individuals who do not meet the above criteria cannot be approved for Medicaid funded waiver services).

**2. DOES THE INDIVIDUAL HAVE A CURRENT SERIOUS MENTAL ILLNESS (MI)?** ___ Yes ___ No
(Check "yes" only if answers a, b, and c below are "yes". If "no", do not refer for assessment of active tx needs for MI Diagnosis.)

a. Is this major mental disorder diagnosable under DSM-IV (e.g., schizophrenia, mood, paranoid, panic, or other serious anxiety disorder; somatoform disorder; personality disorder; other psychotic disorder; or other mental disorder that may lead to a chronic disability)? ___ Yes ___ No

b. Has the disorder resulted in functional limitations in major life activities within the past 3-6 months, particularly with regard to interpersonal functioning; concentration, persistence, or pace; and adaptation to change? __ Yes ___ No

c. Does the treatment history indicate that the individual has experienced psychiatric treatment more intensive than outpatient care more than once in the past 2 years or the individual has experienced within the last 2 years an episode of significant disruption to the normal living situation due to the mental disorder? ___ Yes ___ No

**3. DOES THE INDIVIDUAL HAVE A DIAGNOSIS OF MENTAL RETARDATION (MR) WHICH WAS MANIFESTED BEFORE AGE 18?**
___ Yes ___ No

**4. DOES THE INDIVIDUAL HAVE A RELATED CONDITION?** ___ Yes ___ No
(Check "yes" only if each item below is checked "yes". If "no", do not refer for Level II PAS for related condition.)

a. Is the condition attributable to any other condition (e.g., cerebral palsy, epilepsy, autism, muscular dystrophy, multiple sclerosis, Frederick's ataxia, spina bifida), other than MI, found to be closely related to MR because this condition may result in impairment of general intellectual functioning or adaptive behavior similar to that of MR persons and requires treatment of services similar to those for these persons? ___ Yes ___ No

b. Has the condition manifested before age 22? ____ Yes ___ No

c. Is the condition likely to continue indefinitely? ___ Yes ___ No

d. Has the condition resulted in substantial limitations in 3 or more of the following areas of major life activity: self-care understanding and use of language, learning, mobility, self-direction, and capacity for independent living? ___Yes (circle applicable areas) ___ No

**5. RECOMMENDATION** (Either "a" or "b" MUST be checked.)

a. ____ **Refer for Level II assessment for **:**
___ MI (#2 above is checked "yes")
___ MR or Related Condition (#3 or #4 is checked "yes")
___ Dual diagnosis (MI and MR/Related Condition categories are checked)

****NOTE: If 5a is checked, the individual may NOT be authorized for Medicaid-funded waiver until the CSB has completed the DMAS-101 B.**

b. ____ **No referral for active treatment needs assessment required because individual:**
___ Does not meet the applicable criteria for serious MI or MR or related condition
___ Has a primary diagnosis of dementia (including Alzheimer's disease) and does not have a diagnosis of MR
___ Has a primary diagnosis of dementia (including Alzheimer's disease) AND has a secondary diagnosis of a serious MI
___ Has a severe physical illness (e.g., documented evidence of coma, functioning at brain-stem level, or other conditions which result in a level of impairment so severe that the individual could not be expected to benefit from specialized services)
___ Is terminally ill (note: a physician must have documented that individual's life expectancy is 6 months or less.)

_____ _____ _____
Signature Title Screening Committee

_____ _____ _____
Date Telephone Number Street Address

DMAS-101 A (5/98)

**ASSESSMENT OF ACTIVE TREATMENT NEEDS FOR INDIVIDUALS WITH MI OR MR WHO REQUEST SERVICES UNDER THE ELDERLY AND DISABLED WAVIER**

Attached is an assessment completed by _____ Preadmission Screening Team to determine the need and appropriateness of community based services under the Elderly and Disabled Waiver (personal care, adult day health care and/or respite care) for _____.
*(Individual applying for services)*

As part of our assessment process, we have determined that the individual has:
_____ A condition of mental illness which requires assessment for services needed.
_____ A condition of mental retardation which requires assessment for services needed.

Please complete the information below and return it to _____ _____ within 72
*Name of Screener making referral* *Phone number*
hours of the referral date of _____ so that the assessment and authorization process can be completed.

**TO BE COMPLETED BY THE COMMUNITY SERVICES BOARD (Attach additional information as needed.)**

The _____ Community Services Board assessed the needs of the individual
*(Name of CSB)*
referenced above on _____.
*(Date assessment completed)*

1. ☐ The individual does have a condition of mental illness or mental retardation and has the following active treatment needs:

_____
_____
_____
_____
_____

a. Active treatment needs will be met by:

_____
_____
_____

b. If active treatment needs are met by a third party, please attach verification from the third party that all active treatment needs are being met. Also, if active treatment needs are being met by the school system, please explain how active treatment needs will be met during summer vacation:_____
_____
_____

2. ☐ The individual does have a condition of mental illness or mental retardation, but could not benefit from services. Please explain. ***(Note: If this block is checked, but there is no explanation, services under the E&D waiver cannot be authorized).***

_____
_____
_____

3. ☐ The person does not have a condition of mental illness or mental retardation and therefore does not need treatment or services from the CSB.

Name of individual who completed assessment: (Please print name)_____

Signature of individual who completed assessment: _____

Phone Number:_____ Date signed: _____

DMAS-101 B (5/98)

## *Community-Based Care Recipient Plan of Care Review and Assessment Report*

☐ Initial ☐ Monthly ☐ 6 month Reassessment ☐ Annual LOC Review

Recipient Name: _____ Date of Birth:_____
Medicaid ID Number: _____ Start of Care: _____
Recipient's Current Address: _____ Agency Name: _____
_____ Provider ID Number: _____
Phone: ( ) _____

### *FUNCTIONAL STATUS (Shaded areas denote independence or mechanical dependence)*

| ADLS | Needs No Help | MH Only | Human Help | | MH & Human Help | | Performed By Others | Is Not Performed |
|---|---|---|---|---|---|---|---|---|
| | | | Supervise | Phys. Asst. | Supervise | Phys. Asst. | | |
| Bathing | | | | | | | | |
| Dressing | | | | | | | | |
| Toileting | | | | | | | | |
| Transferring | | | | | | | | |
| Eating/Feeding | | | | | | | | |

| **CONTINENCE** | **Continent** | **Incontinent < Weekly** | **Incontinent Self Care** | **Incontinent Weekly or >** | **External Device Not Self Care** | **Indwelling Cath Not Self Care** | **Ostomy Not Self Care** |
|---|---|---|---|---|---|---|---|
| **Bowel** | | | | | | | |
| **Bladder** | | | | | | | |

**MOBILITY:**

| Needs No Help | MH Only | Human Help | | MH & Human Help | | Confined Moves About | Confined Does Not Move About |
|---|---|---|---|---|---|---|---|
| | | Supervise | Phys. Asst. | Supervise | Phys. Asst. | | |
| | | | | | | | |

**ORIENTATION:**

| **Oriented** | **Disoriented-Some Spheres/Some Time** | **Disoriented- Some Spheres/All Time** | **Disoriented-All Spheres/Some Time** | **Disoriented-All Spheres/All Time** | **Semi-Comatose/ Comatose** |
|---|---|---|---|---|---|
| | | | | | |

**Spheres Affected:** **Source of Info:**

**BEHAVIOR:**

| **Appropriate** | **Wandering/Passive < Than Weekly** | **Wandering/Passive Weekly or >** | **Abusive/Aggressive/ Disruptive< Weekly** | **Abusive/Aggressive/ Disruptive > Weekly** | **Semi-Comatose/ Comatose** |
|---|---|---|---|---|---|
| | | | | | |

**Describe Inappropriate B**ehavior:

Source of Info:

**JOINT MOTION:**
**__Within normal limits or instability corrected 0**
**__Limited motion 1**
**__Instability uncorrected or immobile 2**

**MED. ADMINISTRATION:**
**__Without assistance 0**
**__Administered/monitored by lay person 1**
**__Administered/monitored by professional nursing staff2**

### *MEDICAL/NURSING INFORMATION*

Diagnoses _____
_____
CurrentHealth Status/Condition: _____
_____
Current Medical Nursing Needs:_____
_____
Therapies/Special Medical Procedures:_____
_____
Hospitalizations: Date(s):_____Reason(s):_____

## *SUPPORT SYSTEM*

**Hours Aide Provides Care to Recipient: Total Weekly Hours:_____ Days per Week:_____**
**Other Medicaid/Non-Medicaid Funded Services Received:_____**
**_____**
**Family/Other Support:_____**
**_____**
**_____**
**_____**
**_____**
**Who other than the recipient is to sign the aide records?**
**_____**
**Is Recipient in need of supervision at all times to be maintained safely? ☐ Yes ☐ No**

## *RN SUPERVISION*

**Dates of RN supervisory visits for the last 6 months: _____**
**_____**
**Does the Aide document accurately the care provided? ☐ Yes ☐ No**
**Does the care plan reflect the needs of the Recipient? ☐ Yes ☐ No**
**If No to either, please describe follow-up: _____**
**_____**
**_____**

## *CONSISTENCY AND CONTINUITY*

**Number of Days of No Service In the Last 6 Months: (Do Not include Hospitalizations) _____**
**Number of Aides Assigned to Case in the Last 6 Months: Regular Aides : _____ Sub-Aides: _____**
**Has the recipient or caregiver had any problems with the care provided in the last six months? ☐ Yes ☐ No If Yes, please describe problem(s) and the follow-up taken: _____**

**Is the recipient/caregiver satisfied with the services provided? _____Yes _____No If no, please explain**
**_____**
**What action is the provider taking in response? _____**
**_____**

**Date of most recent DMAS 122: _____ Patient Pay Amount: _____**

**RN Supervisor/Coordinator Signature: _____ Date: _____**

**Aide Present? ☐ Yes ☐ No Name of Aide: _____ Regular Aide ☐ Sub Aide ☐**

**NURSING NOTES: (RNs may utilize space below for documentation of pertinent issues that may occur between home visits)**

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

**RN Signature: _____ Date: _____**

**MEDICAID FUNDED LONG-TERM CARE SERVICE AUTHORIZATION FORM**

Please provide the appropriate answer by either filling in the space or putting the correct code in the box provided.

## I. RECIPIENT INFORMATION:

Last Name: _____ First Name: _____ Birth Date: ___/___/_____

Social Security_____ Medicaid ID _____ Sex: _____

## II. MEDICAID ELIGIBILITY INFORMATION:

Is Individual Currently Medicaid Eligible? ☐
- 1 = Yes
- 2 = Not currently Medicaid eligible, anticipated within 180 days of nursing home admission
- 3 = Not currently Medicaid eligible, not anticipated within 180 days of nursing home admission

If no, has Individual formally applied for Medicaid? ☐
0 = No 1 = Yes

Is Individual currently auxiliary grant eligible? ☐
- 0 = No
- 1 = Yes, or has applied for auxiliary grant
- 2 = No, but is eligible for General Relief

Dept of Social Services:
(Eligibility Responsibility)_____

(Services Responsibility)_____

## III. PRE-ADMISSION SCREENING INFORMATION: (to be completed only by Level I, Level II, or ACR screeners)

**MEDICAID AUTHORIZATION**

**Level of Care** ☐
- 1 = Nursing Facility Services
- 2 = PACE/LTCPHP
- 3 = AIDS/HIV Waiver Services
- 4 = Elderly & Disabled Waiver - Personal Care
- 5 = Elderly & Disabled Waiver - Adult Day Health Care
- 6 = Elderly & Disabled Waiver - ADHC and Personal Care
- 7 = Elderly & Disabled Waiver - Respite
- 10 = Consumer-Directed Personal Attendant Services
- 11 = ACR Residential Living
- 12 = ACR Regular Assisted Living
- 13 = ACR Intensive Assisted Living

**NO MEDICAID SERVICES AUTHORIZED**
- 8 = Other Services Recommended
- 9 = Active Treatment for MI/MR Condition
- 0 = No other services recommended

**Targeted Case Management for ACR** ☐
0 = No 1 = Yes

Assessment Completed ☐
1 = Full Assessment 2 = Short Assessment

**SERVICE AVAILABILITY** ☐
- 1 = Client on waiting list for service authorized
- 2 = Desired service provider not available
- 3 = Service provider available, care to start immediately

**LENGTH OF STAY (If approved for Nursing Home)** ☐
- 1 = Temporary (less than 3 months )
- 2 = Temporary..(less than 6 months)
- 3 = Continuing (more than 6 months)
- 8 = Not Applicable

**LEVEL I/ACR SCREENING IDENTIFICATION**

Name of Level I/ACR screener agency and provider number:

1._____

☐☐☐☐☐☐☐

2._____

☐☐☐☐☐☐☐

**LEVEL II ASSESSMENT DETERMINATION**

Name of Level II Screener and ID number:

1._____

☐☐☐☐☐☐☐

- 0 = Not referred for Level II assessment
- 1 = Referred, Active Treatment needed
- 2 = Referred, Active Treatment not needed
- 3 = Referred, Active Treatment needed but individual chooses nursing home

☐

Did the individual expire after the PAS/ACR Screening decision but before services were received? 1 = Yes 0 = No ☐

**SCREENING CERTIFICATION -** This authorization is appropriate to adequately meet the individual's needs and assures that all other resources have been explored prior to Medicaid authorization for this recipient.

_____ ___/___/_____
**Level I/ACR Screener** **Title** **Date**

_____ ___/___/_____
**Level I/ACR Screener** **Title** **Date**

_____ ___/___/_____
**Level I Physician** **Date**

RECIPIENT NAME _____ MEDICAID ID# _____

PROVIDER AGENCY _____ AGENCY ID# _____

✓ EACH **TASK** TO BE DONE, ENTER TIME NEEDED FOR EACH **CATEGORY** AND ADD FOR **TOTAL** TIME

| CATEGORIES/TASKS | Monday | Tuesday | Wednesday | Thursday | Friday | Saturday | Sunday |
|---|---|---|---|---|---|---|---|
| **1. ADL's** Bathing | | | | | | | |
| Dressing | | | | | | | |
| Toileting | | | | | | | |
| Transfer | | | | | | | |
| Assist Eating | | | | | | | |
| Assist Ambulate | | | | | | | |
| Turn/Change Position | | | | | | | |
| **TIME** | | | | | | | |
| **2. SPECIAL MAINTENANCE** Vital Signs | | | | | | | |
| Supervise Meds | | | | | | | |
| Range of Motion | | | | | | | |
| Wound Care | | | | | | | |
| Bowel/Bladder Program | | | | | | | |
| **TIME** | | | | | | | |
| **3. SUPERVISION TIME** | | | | | | | |
| **4. HOUSEKEEPING** Prepare Meals | | | | | | | |
| Clean Kitchen | | | | | | | |
| Make/Change Beds | | | | | | | |
| Clean Areas Used by Recipient | | | | | | | |
| Shop/List Supplies | | | | | | | |
| Laundry | | | | | | | |
| **TIME** | | | | | | | |
| **TOTAL DAILY TIME** | | | | | | | |

*LEVEL OF CARE DETERMINATION FOR MAXIMUM WEEKLY HOURS*

| | | | |
|---|---|---|---|
| **BATHING SCORE** | ____ | **TRANSFERRING SCORE** | ____ |
| Bathes without help or w/MH only | 0 | Transfers without help/ w/MH only | 0 |
| Bathes w/HH or w/HH & MH | 1 | Transfers w/HH or w/HH & MH | 1 |
| Is bathed | 2 | Is transferred/ does not transfer | 2 |
| **DRESSING** | ____ | **EATING SCORE** | ____ |
| Dresses without help or w/MH only | 0 | Eats without help/ w/MH only | 0 |
| Dresses w/HH or w/HH & MH | 1 | Eats w/ HH or HH & MH | 1 |
| Is dressed or does not dress | 2 | Is fed: spoon/tube/IV, etc. | 2 |
| **AMBULATION SCORE** | ____ | **CONTINENCY SCORE** | ____ |
| Walks/Wheels without help/ w/MH only | 0 | Continent/Incontinent < weekly/self care of Internal/ external devices | 0 |
| Walks/Wheels w/HH or HH & MH | 1 | Incontinent weekly or >/Not self care | 2 |
| Totally Dependent for mobility | 2 | | |

*LEVEL OF CARE SCORE=* ___ A (Score 0-6) ___ B (Score 7-12) ___ C (Score 9+ Wounds, Tube Feedings, Etc.)

LOC A=MAXIMUM HOURS 25/WK LOC B=MAXIMUM HOURS 30/WK LOC C=MAXIMUM HOURS 35/WK

**REASON PLAN OF CARE SUBMITTED**: ___ NEW ADMISSION ___ ↓ IN HOURS ___ ↑ IN HOURS ___ TRANSFER

Reason For Change/Additional Instructions For The Aide: _____

_____

**Plan Of Care Effective Date** _____ **Total Weekly Hours** _____ **Rn Signature** _____

DMAS 97-A, Revised 8/94

PROVIDER COPY

PROVIDER NOTIFICATION TO CLIENT

This Plan of Care has been revised based on your current needs and available support. If you agree with the changes, no action is required on your part. If you do not agree with the changes, you may contact the RN Supervisor who has signed the plan of care to discuss the reason you disagree with the change.

If the person you contact is unwilling or unable to change the information you disagree with, you have the right to request reconsideration by notifying, in writing, the Community-Based Care Supervisor, Department of Medical Assistance Services, 600 East Broad Street, Suite 1300, Richmond, VA 23219. This written request for reconsideration must be filed within thirty (30) days of the time you receive this notification. If you file a request for reconsideration before the effective date of this action, _____ services may continue unchanged during the reconsideration process. (effective date )

DMAS NOTIFICATION TO CLIENT

The provider submitted this Plan of Care to the Department of Medical Assistance Services (DMAS) to request approval of the changes noted. DMAS has _____ this request.

If you disagree with the DMAS decision, you have the right to appeal by notifying, in writing, the Division of Client Appeals, Department of Medical Assistance Services, 600 East Broad Street, Suite 1300, Richmond, VA 23219. This written request for appeal must be filed within thirty (30) days of the time you receive this notification. If you file a request for appeal before the effective date of this action, _____ services may continue unchanged during the reconsideration process. (effective date )

_____

Analyst Signature and Date

Instructions for Completion of the DMAS-97-A

LEVEL OF CARE DETERMINATION FOR MAXIMUM WEEKLY HOURS

Enter a score for Each activity of daily living (ADL) based on the client's current functioning. Sum Each ADL Rating & Enter The Composite Score Under The Appropriate Category: A, B or C. **The amount of time allocated under TOTAL DAILY TIME to complete all tasks Must Not Exceed the maximum weekly hours for the specified LOC.**

PROVIDER NOTIFICATION TO CLIENT

Anytime the RN Supervisor changes the plan of care which results in a change in the total number of weekly hours, the RN must complete the entire front section of this form. If the change the agency is making does not require DMAS approval, the RN Supervisor is required to enter the effective date on the Provider Agency Client Notification Section which gives the client their right to reconsideration and make sure the client gets a copy of both the front and back of the form

DMAS NOTIFICATION TO CLIENT

If the changes to the care plan require DMAS approval, the entire front portion of this form must be completed and forwarded to the agency's assigned analyst for approval . If supervision is requested, please remember to attach the Request for Supervsion form (DMAS 100). Once received by DMAS, the assigned analyst will review the care plan and indicate whether the request is approved or denied Once the decision is made, this form will be sent back to the provider agency who is responsible for making sure the client receives a copy of the back of this form (as well as the front) which gives the client's right to appeal.

**REQUEST FOR SUPERVISION IN PERSONAL CARE PLAN OF CARE**

Recipient Name: _____ Medicaid Number:_____

Provider Name: _____ Provider Number: _____

**I. RECIPIENT COGNITIVE AND PHYSICAL NEEDS WHICH CREATE NEED FOR SUPERVISION**

**A. Cognitive Impairment:** Describe the recipient's level of confusion and impact it has on their behavior. If confusion is greater at different times of the day, explain. Give a detailed description of any behaviors that would present a danger to the recipient without supervision in place.

**B. Physical Incapacity**: Describe the degree of physical incapacity and how it creates a need for supervision by answering the following questions.

1. *Incontinence:*
   Bowel ____ Frequency of Changes _____ Bladder ____Frequency of Changes _____
   Can Recipient Shift Position/Transfer Self without Assistance?

   Skin Breakdown: Note Area Affected/Recent Documented Problems & Dates within Last Year

   Potential for skin breakdown: Assess potential based on needed frequency of changes, ability to shift position, condition/history of skin integrity. Note whether the potential for skin breakdown is temporary orexpected to continue.

2. *Falls:*Describe any falls which have occurred during the past 3 months; give dates, activity being completed when the fall occurred; time of day fall occurred, possible role of medication (interactions, side effects), interventions which have been attempted to reduce likelihood of falls (removing barriers, obtaining BSC, structuring activities when help is present), recipient's use of judgement/denial of abilities.

3. *Unstable Medical Condition:* Describe recipient's needs in relation to an unstable medical condition.
   List current diagnoses_____
   Seizures: Note Frequency/Severity within the past 3 months.

   Immobility: Discuss the degree to which the recipient is unable to ambulate due to the fact that any movement will exacerbate their medical condition or create risk of injury.

**C. RECIPIENT'S ABILITY TO CALL FOR HELP:**
Recipient Can Call (via telephone) For Assistance _____ Yes _____ No, Reason:

**I. Support System:**

Primary Caretaker's Name_____ Home Phone # _____
Primary Caretaker Lives With Recipient? _____ If no, Address: _____
Primary Caretaker Works? _____ If yes, Work Place/Telephone#:_____
Work Hours:_____ Leaves home for work:_____ Returns from work_____
List Support/Back-Up for the Primary Caretaker when Personal Care Aide is not in the home, include family/friends, other services received (e.g. Adult Day Care Program)

Discuss whether the primary caretaker or support is available during times when recipient would be alone and could respond to recipient's call for assistance (i.e. could respond promptly if recipient fell, could come in to change recipient, etc) and whether this support is sufficient to meet the needs addressed in the previous section.

**III. ASSESSMENT OF RECIPIENT NEEDS**

1. Recipient can be left alone without presenting a danger to self: ___ Yes ___ No
2. Recipient has ability to phone 911 in an emergency:_____Yes _____No

**IV. PLAN OF CARE REQUIREMENTS TO PROVIDE NECESSARY SUPERVISION**

Amount of Time in the Plan of Care for ADL care and Home Maintenance Requirements: _____

Amount of Additional Time Required for Supervision , Which Cannot be Provided by Recipient's Support System

_____ Hours, Provided Between _____ and _____

_____ _____
RN SUPERVISOR OR PAS TEAM MEMBER AGENCY DATE

DMAS-100 8/00 j:\cbc\forms\supervis

# RESPITE CARE NEEDS ASSESSMENT AND PLAN OF CARE

**A. NAME**_____ **MEDICAID NO.**_____

**B. PRIMARY CAREGIVER** _____ **RELATIONSHIP TO CLIENT**_____

**C. STRESSORS: Describe factors that create a need for Respite Care.**

LACK OF ADDITIONAL SUPPORT_____

_____

OTHER DEPENDENTS_____

24-HOUR SUPERVISION REQUIRED_____

_____

ILLNESSES/LIMITATIONS_____

OTHER_____

_____

**D. AMOUNT AND TYPE OF RESPITE CARE NEEDED**

REASON RESPITE CARE REQUESTED_____

_____

_____ROUTINE HOURS PER DAY_____ DAYS NEEDED_____

_____EPISODIC HOURS PER DAY____ SPECIFIC DAYS NEEDED_____

**CARE MUST BE PROVIDED BY LPN ____NO ____YES** Describe Skilled Needs_____

**E. PATIENT PAY**

PATIENT PAY INFORMATION OBTAINED FROM _____ _____

**Eligibility Worker's Name** **Phone Number**

**F. FREEDOM OF CHOICE**

**In accordance with the policies and procedures of the Department of Medical Assistance Services I have been informed by**

_____ **Pre-Admission Screening team of the Medicaid funded, long-term care**

Name of City/County or Hospital

**options available to me and I choose**:

## □ Respite Care Service □ Nursing Home Placement

**I have been given a choice of the available Respite Care Providers and my choice is _____. I understand that only the amount of Respite Care authorized above can be offered. In order to receive Respite Care (and any additional Medicaid-funded Home and Community-Based Care services) must be equal to or less than the cost to Medicaid for nursing home care. The Pre-Admission Screening team has determined that the above Plan of Care is cost-effective, appropriate to meet my health and safety needs and necessary to avoid nursing home care.**

_____ _____ _____ _____

**PHYSICIAN SIGNATURE** **DATE** **RECIPIENT/FAMILY SIGNATURE** **DATE**

**SCREENING TEAM PLAN OF CARE FOR MEDICAID-FUNDED LONG TERM CARE**

**Individual Being Screened: _____ Medicaid ID #_____**

***I. SCREENING TEAM DETERMINATION*: Refer to Appendix B, NHPAS manual**

**A. Individual Meets Nursing Facility Criteria (Functional Dependency Level and Medical/Nursing Need Present): _____**
*(Must be checked to authorize Nursing Facility Placement)*

**B. Individual is At Imminent Risk (within 30 days of application) of Nursing Facility Placement if Community-Based Care Is Not Offered: _____**

☐Application for the individual to a nursing facility has been made and accepted. Date application was made _____ Facility _____ Contact _____

☐Deterioration in individual's health care condition or changes in available support prevents former care arrangements from meeting needs. Describe: _____

☐Evidence is available that demonstrates person's medical and nursing needs are not being met (e.g. Recent hospitalization; doctor's documentation of instability, findings from medical/social service agencies). Describe:_____
_____

**Complete Section II ONLY if nursing facility criteria *and* risk of Nursing Facility placement Are Met**

***II. COMMUNITY CARE CHOICE AND PAYMENT RESPONSIBLITY***

Medicaid will pay for someone to come into your home to care for you as long as in-home care will safely meet your needs and will not be more expensive than nursing home care. You may choose to receive in-home services as long as there is an available provider in your area and either you have some additional support from family or friends or you are able to manage without additional help when the home care is not being provided. To stay at home, help in the following areas is needed: ☐ADL's ☐Housekeeping ☐Meal Preparation ☐Shopping ☐Laundry ☐Supervision ☐Transportation ☐Skilled Needs. Please identify any people or agencies that are able to provide you with assistance, either on a regular basis or as needed:

| People/Agencies | What Areas of Help Will They Provide | # Days & Hours/Week |
|---|---|---|
| _____ | _____ | _____ |
| _____ | _____ | _____ |

**I choose to receive the following community care instead of nursing home care:**

☐Consumer-Directed Personal Attendant Services requested _____ days/week

☐Personal Care Services requested _____days/week. ***Special Needs (Check any required for the recipient's safe care)***:

___ *Split Shift* ___hrs. in am ___ hrs. in p.m. ____*Supervision* time is needed (Attach Supervision Request Form)

___ *Special Maintenance Activities* (e.g. bowel program, range of motion, routine wound care): Describe_____

___ *Weekend Care is Necessary Due To*: _____

☐Adult Day Health Care Services requested _____days/week from _____a.m. to _____p.m. Transportation is Needed: _____.

_____ (Provider) has been chosen and contacted and is able to provide the care requested. I understand that the provider will develop with me a plan of care based on my needs and my available support. Provider staff are responsible to provide continuous, reliable care but there may be an occasional lapse in service for which I will need to provide back-up support. (Under Consumer-Directed Personal Attendant Services, I understand the responsibilities associated with employing my own personal attendants). I understand that, based on my income, I may have a co-pay of $_____/month regardless of the amount of community care received.

_____ _____ _____ _____
Client Signature Date Screener Signature Date

***III. NURSING FACILITY CHOICE AND PAYMENT RESPONSIBLITY:***

Community Care alternatives were explained completely but were not an option for me because _____

_____

☐ I choose to receive nursing facility care and am requesting admission to _____(facility) I understand that I may have to pay $_____/mo. in order to receive nursing facility care. Community/ in-home care has been explained completely and I understand the options for care that are available? ☐**Yes** ☐**No**

_____ _____ _____ _____
Client Signature Date Screener Signature Date

\

## Instructions For Completing the DMAS-97

Complete this form only if you are authorizing nursing facility or Community-Based Care services.

**Section I: Screening Determination**

Item A must be checked if authorizing Nursing Facility Placement

Item A or at least one of the conditions in B must be completed if authorizing Community-Based Care Services

**Section II: Community Care Choice and Payment Responsibility**

Section II must be completed in its entirety if Community Based Care criteria is met and client chooses Community Based Care Services. Please remember to obtain client's signature that assures the client was given a choice of providers and was advised of their possible patient pay responsibility.

The Screening Team must explain to the client that the Screening Team does not authorize the amount of services or times of day or days of week on which services will be provided. The provider will make that decision with the client based on their needs and wishes identified during the screening.

**Section III: Nursing Facility Choice and Payment Responsibility**

Section III must be completed in its entirety if Nursing Facility Criteria is met and the recipient chooses Nursing Facility Placement. Please remember to obtain client's signature that assures the client was offered Community-Based Care alternatives and chooses Nursing Facility Placement

## AIDE RECORD

RECIPIENT NAME: _____ ADDRESS/PHONE: _____

| DAY | MONDAY | TUESDAY | WEDNESDAY | THURSDAY | FRIDAY | SATURDAY | SUNDAY |
|---|---|---|---|---|---|---|---|
| DATE (Month/Day/Year) | | | | | | | |
| ACTIVITY: | | | | | | | |
| Complete/Partial Bath | | | | | | | |
| Dress/Undress | | | | | | | |
| Assist with Toileting | | | | | | | |
| Transferring | | | | | | | |
| Personal Grooming | | | | | | | |
| Assist with Eat-Feed | | | | | | | |
| Ambulation | | | | | | | |
| Turn/Change Position | | | | | | | |
| Vital Signs | | | | | | | |
| Assist with Self-Admin. Medication | | | | | | | |
| Bowel/Bladder | | | | | | | |
| Wound Care | | | | | | | |
| ROM | | | | | | | |
| Supervision | | | | | | | |
| Prepare Breakfast | | | | | | | |
| Prepare Lunch | | | | | | | |
| Prepare Dinner | | | | | | | |
| Clean Kitchen Wash Dishes | | | | | | | |
| Make/Change Bed Linen | | | | | | | |
| Clean Areas Used by Recipient | | | | | | | |
| Listing Supplies/ Shopping | | | | | | | |
| Recipient's Laundry | | | | | | | |
| TIME IN | | | | | | | |
| TIME OUT | | | | | | | |
| NUMBER OF HOURS | | | | | | | |

**WEEKLY COMMENTS:** **DATE:**

_____

_____

_____

_____

**WEEKLY SIGNATURES:**

_____ _____

RECIPIENT/FAMILY SIGNATURE DATE AIDE SIGNATURE DATE

_____ _____

SUBSTITUTE AIDE DATE RN SIGNATURE DATE

**DMAS-90 Rev. 11/90**

# CONSENT TO EXCHANGE INFORMATION

*I understand that different agencies provide different services and benefits. Each agency must have specific information in order to provide services and benefits. By signing this form, I am allowing agencies to exchange certain information so it will be easier for them to work together effectively to provide or coordinate these services or benefits.*

I, _____, am signing this form for
(FULL PRINTED NAME OF CONSENTING PERSON OR PERSONS)

_____
(FULL PRINTED NAME OF CLIENT)

_____
(CLIENT'S ADDRESS) (CLIENT'S BIRTH DATE) (CLIENT'S SSN – OPTIONAL)

My relationship to the client is: ☐ Self ☐ Parent ☐ Power of Attorney ☐ Guardian
☐ Other Legally Authorized Representative

I want the following confidential information about the client (except drug or alcohol abuse diagnoses or treatment information) to be exchanged:

| Yes | No | | Yes | No | | Yes | No | |
|---|---|---|---|---|---|---|---|---|
| ☐ | ☐ | Assessment Information | ☐ | ☐ | Medical Diagnosis | ☐ | ☐ | Educational Records |
| ☐ | ☐ | Financial Information | ☐ | ☐ | Mental Health Diagnosis | ☐ | ☐ | Psychiatric Records |
| ☐ | ☐ | Benefits/Services Needed Planned, and/or Received | ☐ | ☐ | Medical Records | ☐ | ☐ | Criminal Justice Records |
| | | | ☐ | ☐ | Psychological Records | ☐ | ☐ | Employment Records |

Other Information (write in):
I want:_____

_____
(*NAME AND ADDRESS OF REFERRING AGENCY AND STAFF CONTACT PERSON)*

And the following other agencies to be able to exchange this information:

*Are More Agencies Listed on the Back?* ☐ Yes ☐ No

I want this information to be exchanged ONLY for the following purpose(s);
☐ Service Coordination and Treatment Planning ☐ Eligibility Determination
Other:_____

I want information to be shared: (check all that apply)
☐ Written Information ☐ In Meetings or By Phone ☐ Computerized Data

I want to share additional information received after this consent is signed: ☐ YES ☐ NO

This consent is good until:_____

I can withdraw this consent at any time by telling the referring agency. This will stop the listed agencies from sharing information after they know my consent has been withdrawn.

I have the right to know what information about me has been shared, and why, when, and with whom it was shared. If I ask, each agency will show me this information.

*I want all the agencies to accept a copy of this form as a valid consent to share information.*

**IF I do not sign this form, information will not be shared and I will have to contact each agency individually to give them information about me that they need.**

Signature(s):_____ Date:_____
(CONSENTING PERSON OR PERSONS)

Person Explaining Form*:*_____
*(*Name) (Title) (Phone Number**)**

Witness (If Required)*:*_____
*(Signature) (Address) (Phone Number)*

DMAS 20
6/94

# CONSENT TO EXCHANGE INFORMATION FORM

FULL PRINTED NAME OF CLIENT:_____

**FOR AGENCY USE ONLY**

CONSENT HAS BEEN:

- ☐ Revoked in entirety
- ☐ Partially revoked as follows:

NOTIFICATION THAT CONSENT WAS REVOKED WAS BY:

☐ Letter (Attach Copy) ☐

Telephone ☐ In Person

DATE REQUEST RECEIVED:_____

AGENCY REPRESENTATIVE RECEIVING REQUEST:

_____

(*AGENCY REPRESENTATIVE'S FULL NAME AND TITLE)*

# VIRGINIA UNIFORM ASSESSMENT INSTRUMENT

**Dates:** Screen: ___/___/___
Assessment: ___/___/___
Reassessment: ___/___/___

## 1 IDENTIFICATION/BACKGROUND

### Name & Vital Information

**Client Name:** _____ **Client SSN:** ___-___-___
(Last) (First) (Middle Initial)

**Address:** _____
(Street) (City) (State) (Zip Code)

**Phone:** ( ) _____ **City/County Code:** _____ _____ _____

**Directions to House:** **Pets?**

### Demographics

**Birthdate:** ___/___/___ **Age:** _____ **Sex:** ___ Male 0 ___ Female 1
(Month) (Day) (Year)

**Marital Status:** ___ Married 0 ___ Widowed 1 ___ Separated 2 ___ Divorced 3 ___ Single 4 ___ Unknown 9

**Race:**
___ White 0
___ Black/African American 1
___ American Indian 2
___ Oriental/Asian 3
___ Alaskan Native 4
___ Unknown 9 _____
Ethnic Origin: _____

**Education:**
___ Less than High School 0
___ Some High School 1
___ High School Graduate 2
___ Some College 3
___ College Graduate 4
___ Unknown 9
Specify: _____

**Communication of Needs:**
___ Verbally, English 0
___ Verbally, Other Language 1
Specify: _____
___ Sign Language/Gestures/Device 2
___ Does Not Communicate 3
Hearing Impaired? _____

### Primary Caregiver/Emergency Contact/Primary Physician

**Name:** _____ **Relationship:** _____
**Address:** _____ **Phone:** (H) _____ (W) _____
**Name:** _____ **Relationship:** _____
**Address:** _____ **Phone:** (H) _____ (W) _____
**Name of Primary Physician:** _____ **Phone:** _____
**Address:** _____

### Initial Contact

**Who called:** _____
(Name) (Relation to Client) (Phone)

**Presenting Problem/Diagnosis:**

CLIENT NAME: Client SSN: - -

## Current Formal Services

**Do you currently use any of the following types of services?**

| No 0 | Yes 1 | *Check All Services That Apply* | **Provider/Frequency:** |
|---|---|---|---|
| ___ | ___ | Adult Day Care | |
| ___ | ___ | Adult Protective | |
| ___ | ___ | Case Management | |
| ___ | ___ | Chore/Companion/Homemaker | |
| ___ | ___ | Congregate Meals/Senior Center | |
| ___ | ___ | Financial Management/Counseling | |
| ___ | ___ | Friendly Visitor/Telephone Reassurance | |
| ___ | ___ | Habilitation/Supported Employment | |
| ___ | ___ | Home Delivered Meals | |
| ___ | ___ | Home Health/Rehabilitation | |
| ___ | ___ | Home Repairs/Weatherization | |
| ___ | ___ | Housing | |
| ___ | ___ | Legal | |
| ___ | ___ | Mental Health (Inpatient/Outpatient) | |
| ___ | ___ | Mental Retardation | |
| ___ | ___ | Personal Care | |
| ___ | ___ | Respite | |
| ___ | ___ | Substance Abuse | |
| ___ | ___ | Transportation | |
| ___ | ___ | Vocational Rehab/Job Counseling | |
| ___ | ___ | Other: _____ | |

## Financial Resources

**Where are you on this scale for annual (monthly) family income before taxes?**

___ $20,000 or More ($1,667 or More) 0
___ $15,000 - $19,999 ($1,250 - $1,666) 1
___ $11,000 - $14,999 ($ 917 - $1,249) 2
___ $ 9,500 - $10,999 ($ 792 - $ 916) 3
___ $ 7,000 - $ 9,499 ($ 583 - $ 791) 4
___ $ 5,500 - $ 6,999 ($ 458 - $ 582) 5
___ $ 5,499 or Less ($ 457 or Less) 6
___ Unknown 9

Number in Family unit: _____

*Optional: Total monthly family income:* _____

**Do you currently receive income from . . . ?**

| No 0 | Yes 1 | | *Optional: Amount* |
|---|---|---|---|
| ___ | ___ | Black Lung, | |
| ___ | ___ | Pension, | |
| ___ | ___ | Social Security, | |
| ___ | ___ | SSI/SSDI, | |
| ___ | ___ | VA Benefits, | |
| ___ | ___ | Wages/Salary, | |
| ___ | ___ | Other, | |

**Does anyone cash your check, pay your bills or manage your business?**

| No 0 | Yes 1 | | *Names* |
|---|---|---|---|
| ___ | ___ | Legal Guardian, | |
| ___ | ___ | Power of Attorney, | |
| ___ | ___ | Representative Payee, | |
| ___ | ___ | Other, | |

**Do you receive any benefits or entitlements?**

| No 0 | Yes 1 | |
|---|---|---|
| ___ | ___ | Auxiliary Grant |
| ___ | ___ | Food Stamps |
| ___ | ___ | Fuel Assistance |
| ___ | ___ | General Relief |
| ___ | ___ | State and Local Hospitalization |
| ___ | ___ | Subsidized Housing |
| ___ | ___ | Tax Relief |

**What types of health insurance do you have?**

| No 0 | Yes 1 | |
|---|---|---|
| ___ | ___ | Medicare, # _____ |
| ___ | ___ | Medicaid, # _____ |
| | | *Pending:* ☐ No 0 ☐ Yes 1 |
| | | *QMB/SLMB:* ☐ No 0 ☐ Yes 1 |
| ___ | ___ | All Other Public/Private: _____ |

CLIENT NAME: Client SSN: - -

# Physical Environment

**Where do you usually live? Does anyone live with you?**

| | Alone 1 | Spouse 2 | Other 3 | Names of Persons in Household |
|---|---|---|---|---|
| ___ House: Own 0 | | | | |
| ___ House: Rent 1 | | | | |
| ___ House: Other 2 | | | | |
| ___ Apartment 3 | | | | |
| ___ Rented Room 4 | | | | |

| | Name of Provider (Place) | Admission Date | Provider Number (If Applicable) |
|---|---|---|---|
| ___ Adult Care Residence 50 | | | |
| ___ Adult Foster 60 | | | |
| ___ Nursing Facility 70 | | | |
| ___ Mental Health/ Retardation Facility 80 | | | |
| ___ Other 90 | | | |

**Where you usually live, are there any problems?**

| No 0 | Yes 1 | *Check All Problems That Apply* |
|---|---|---|
| ___ | ___ | Barriers to Access |
| ___ | ___ | Electrical Hazards |
| ___ | ___ | Fire Hazards/No Smoke Alarm |
| ___ | ___ | Insufficient Heat/Air Conditioning |
| ___ | ___ | Insufficient Hot Water/Water |
| ___ | ___ | Lack of/Poor Toilet Facilities (Inside/Outside) |
| ___ | ___ | Lack of/Defective Stove, Refrigerator, Freezer |
| ___ | ___ | Lack of/Defective Washer/Dryer |
| ___ | ___ | Lack of/Poor Bathing Facilities |
| ___ | ___ | Structural Problems |
| ___ | ___ | Telephone Not Accessible |
| ___ | ___ | Unsafe Neighborhood |
| ___ | ___ | Unsafe/Poor Lighting |
| ___ | ___ | Unsanitary Conditions |
| ___ | ___ | Other: _____ |

**Describe Problems:**

**CLIENT NAME:** **Client SSN:** - -

## 2 FUNCTIONAL STATUS (Check only one block for each level of functioning)

| ADLS | Needs Help? | | MH Only 10 Mechanical Help | HH Only 2 Human Help | | MH & HH 3 | | Performed by Others 40 | | | Is Not Performed 50 |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | No 00 | Yes | | Supervision 1 | Physical Assistance 2 | Supervision 1 | Physical Assistance 2 | | | | |
| Bathing | | | | | | | | | | | |
| Dressing | | | | | | | | | | | |
| Toileting | | | | | | | | | | | |
| Transferring | | | | | | | | | | | |
| | | | | | | | | Spoon Fed 1 | Syringe/ Tube Fed 2 | Fed by IV 3 | |
| Eating/Feeding | | | | | | | | | | | |

| Continence | Needs Help? | | Incontinent Less than weekly 1 | External Device/ Indwelling/ Ostomy Self care 2 | Incontinent Weekly or more 3 | External Device Not self care 4 | Indwelling Catheter Not self care 5 | Ostomy Not self care 6 |
|---|---|---|---|---|---|---|---|---|
| | No 00 | Yes | | | | | | |
| Bowel | | | | | | | | |
| Bladder | | | | | | | | |

**Comments:**

| Ambulation | Needs Help? | | MH Only 10 Mechanical Help | HH Only 2 Human Help | | MH & HH 3 | | Performed by Others 40 | Is Not Performed 50 |
|---|---|---|---|---|---|---|---|---|---|
| | No 00 | Yes | | Supervision 1 | Physical Assistance 2 | Supervision 1 | Physical Assistance 2 | | |
| Walking | | | | | | | | | |
| Wheeling | | | | | | | | | |
| Stairclimbing | | | | | | | | | |
| | | | | | | | | Confined Moves About | Confined Does Not Move About |
| Mobility | | | | | | | | | |

| IADLS | Needs Help? | |
|---|---|---|
| | No 0 | Yes 1 |
| Meal Preparation | | |
| Housekeeping | | |
| Laundry | | |
| Money Management | | |
| Transportation | | |
| Shopping | | |
| Using Phone | | |
| Home Maintenance | | |

**Comments:**

**Outcome: Is this a short assessment?**

___ No, Continue with **Section** 0 ___ Yes, Service Referrals 1 ___ Yes, No Service Referrals 2

**Screener:** _____ **Agency:** _____

CLIENT NAME: Client SSN: - -

# 3 PHYSICAL HEALTH ASSESSMENT

## Professional Visits/Medical Admissions

| Doctor's Name(s) *(List all)* | Phone | Date of Last Visit | Reason for Last Visit |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

**Admissions: In the past 12 months, have you been admitted to a . . . for medical or rehabilitation reasons?**

| No 0 | Yes 1 | | Name of Place | Admit Date | Length of Stay/Reason |
|---|---|---|---|---|---|
| | | Hospital | | | |
| | | Nursing Facility | | | |
| | | Adult Care Residence | | | |

**Do you have any advanced directives such as . . . (Who has it . . . Where is it . . . )?**

No 0 Yes 1 *Location*

___ ___ Living Will, _____

___ ___ Durable Power of Attorney for Health Care, _____

___ ___ Other, _____

## Diagnoses & Medication Profile

**Do you have any current medical problems, or a known or suspected diagnosis of mental retardation or related conditions, such as . . . (Refer to the list of diagnoses)?**

**Current Diagnoses** **Date of Onset**

_____

_____

_____

_____

_____

**Enter Codes for 3 Major, Active Diagnoses:** _____ None 00 _____ DX1 _____ DX2 _____ DX3

| | Current Medications (Include Over-the-Counter) | Dose, Frequency, Route | Reason(s) Prescribed |
|---|---|---|---|
| 1. | | | |
| 2. | | | |
| 3. | | | |
| 4. | | | |
| 5. | | | |
| 6. | | | |
| 7. | | | |
| 8. | | | |
| 9. | | | |
| 10. | | | |

**Total No. of Medications:** _____ (If 0, skip to Sensory Function) **Total No. of Tranquilizer/Psychotropic Drugs:** _____

**Do you have any problems with medicine(s) . . . ?**

No 0 Yes 1

___ ___ Adverse reactions/allergies

___ ___ Cost of medication

___ ___ Getting to the pharmacy

___ ___ Taking them as instructed/prescribed

___ ___ Understanding directions/schedule

**How do you take your medicine(s)?**

___ Without assistance 0

___ Administered/monitored by lay person 1

___ Administered/monitored by professional nursing staff 2

Describe help: _____

Name of helper: _____

**Diagnoses:**

**Alcoholism/Substance Abuse** (01)
**Blood-Related Problems** (02)
**Cancer** (03)
**Cardiovascular Problems**
- Circulation (04)
- Heart Trouble (05)
- High Blood Pressure (06)
- Other Cardiovascular Problems (07)

**Dementia**
- Alzheimer's (08)
- Non-Alzheimer's (09)

**Developmental Disabilities**
- Mental Retardation (10)
- Related Conditions
  - Autism (11)
  - Cerebral Palsy (12)
  - Epilepsy (13)
  - Friedreich's Ataxia (14)
  - Multiple Sclerosis (15)
  - Muscular Dystrophy (16)
  - Spina Bifida (17)

**Digestive/Liver/Gall Bladder** (18)
**Endocrine (Gland) Problems**
- Diabetes (19)
- Other Endocrine Problems (20)

**Eye Disorders** (21)
**Immune System Disorders** (22)
**Muscular/Skeletal**
- Arthritis/Rheumatoid Arthritis (23)
- Osteoporosis (24)
- Other Muscular/Skeletal Problems (25)

**Neurological Problems**
- Brain Trauma/Injury (26)
- Spinal Cord Injury (27)
- Stroke (28)
- Other Neurological Problems (29)

**Psychiatric Problems**
- Anxiety Disorders (30)
- Bipolar (31)
- Major Depression (32)
- Personality Disorder (33)
- Schizophrenia (34)
- Other Psychiatric Problems (35)

**Respiratory Problems**
- Black Lung (36)
- COPD (37)
- Pneumonia (38)
- Other Respiratory Problems (39)

**Urinary/Reproductive Problems**
- Renal Failure (40)
- Other Urinary/Reproductive Problems (41)

**All Other Problems** (42)

CLIENT NAME: Client SSN: - -

## Sensory Functions

**How is your vision, hearing, and speech?**

| | No Impairment 0 | Impairment Record Date of Onset/Type of Impairment | | Complete Loss 3 | Date of Last Exam |
|---|---|---|---|---|---|
| | | Compensation 1 | No Compensation 2 | | |
| Vision | | | | | |
| Hearing | | | | | |
| Speech | | | | | |

## Physical Status

**Joint Motion: How is your ability to move your arms, fingers and legs?**

___ Within normal limits or instability corrected 0
___ Limited motion 1
___ Instability uncorrected or immobile 2

**Have you ever broken or dislocated any bones . . . Ever had an amputation or lost any limbs . . . Lost voluntary movement of any part of your body?**

| Fractures/Dislocations | Missing Limbs | Paralysis/Paresis |
|---|---|---|
| ___ None 000 | ___ None 000 | ___ None 000 |
| ___ Hip Fracture 1 | ___ Finger(s)/Toe(s) 1 | ___ Partial 1 |
| ___ Other Broken Bone(s) 2 | ___ Arm(s) 2 | ___ Total 2 |
| ___ Dislocation(s) 3 | ___ Leg(s) 3 | Describe: _____ |
| ___ Combination 4 | ___ Combination 4 | _____ |
| **Previous Rehab Program?** | **Previous Rehab Program?** | **Previous Rehab Program?** |
| ___ No/Not Completed 1 | ___ No/Not Completed 1 | ___ No/Not Completed 1 |
| ___ Yes 2 | ___ Yes 2 | ___ Yes 2 |
| **Date of Fracture/Dislocation?** | **Date of Amputation?** | **Onset of Paralysis?** |
| ___ 1 Year or Less 1 | ___ 1 Year or Less 1 | ___ 1 Year or Less 1 |
| ___ More than 1 Year 2 | ___ More than 1 Year 2 | ___ More than 1 Year 2 |

## Nutrition

**Height:** _____ (inches) **Weight:** _____ (lbs.) **Recent Weight Gain/Loss:** ___ No 0 ___ Yes 1

**Describe:** _____

**Are you on any special diet(s) for medical reasons?**

___ None 0
___ Low Fat/Cholesterol 1
___ No/Low Salt 2
___ No/Low Sugar 3
___ Combination/Other 4

**Do you take dietary supplements?**

___ None 0
___ Occasionally 1
___ Daily, Not Primary Source 2
___ Daily, Primary Source 3
___ Daily, Sole Source 4

**Do you have any problems that make it hard to eat?**

| No 0 | Yes 1 | |
|---|---|---|
| ___ | ___ | Food Allergies |
| ___ | ___ | Inadequate Food/Fluid Intake |
| ___ | ___ | Nausea/Vomiting/Diarrhea |
| ___ | ___ | Problems Eating Certain Foods |
| ___ | ___ | Problems Following Special Diets |
| ___ | ___ | Problems Swallowing |
| ___ | ___ | Taste Problems |
| ___ | ___ | Tooth or Mouth Problems |
| ___ | ___ | Other: _____ |

CLIENT NAME: Client SSN: - -

## Current Medical Services

**Rehabilitation Therapies: Do you get any therapy prescribed by a doctor, such as . . . ?**

No 0 Yes 1 *Frequency*

___ ___ Occupational ___
___ ___ Physical ___
___ ___ Reality/Remotivation ___
___ ___ Respiratory ___
___ ___ Speech ___
___ ___ Other ___

**Do you have any pressure ulcers?**

___ None 0 *Location/Size*
___ Stage I 1 ___
___ Stage II 2 ___
___ Stage III 3 ___
___ Stage IV 4 ___

**Special Medical Procedures: Do you receive any special nursing care, such as . . . ?**

No 0 Yes 1 *Site, Type, Frequency*

___ ___ Bowel/Bladder Training ___
___ ___ Dialysis ___
___ ___ Dressing/Wound Care ___
___ ___ Eyecare ___
___ ___ Glucose/Blood Sugar ___
___ ___ Injections/IV Therapy ___
___ ___ Oxygen ___
___ ___ Radiation/Chemotherapy ___
___ ___ Restraints (Physical/Chemical) ___
___ ___ ROM Exercise ___
___ ___ Trach Care/Suctioning ___
___ ___ Ventilator ___
___ ___ Other: ___

## Medical/Nursing Needs

*Based on client's overall condition, assessor should evaluate medical and/or nursing needs.*

**Are there ongoing medical/nursing needs?** ___ No 0 ___ Yes 1

**If yes, describe ongoing medical/nursing needs:**

1. Evidence of medical instability.
2. Need for observation/assessment to prevent destabilization.
3. Complexity created by multiple medical conditions.
4. Why client's condition requires a physician, RN, or trained nurse's aide to oversee care on a daily basis.

**Comments:**

*Optional:* Physician's Signature: ___ Date: ___

Others: ___ Date: ___
(Signature/Title)

CLIENT NAME: Client SSN: - -

# 4 PSYCHO-SOCIAL ASSESSMENT

## Cognitive Function

### Orientation *(Note: Information in italics is optional and can be used to give a MMSE Score in the box to the right.)*

**Person:** **Please tell me your full name** (so that I can make sure our record is correct).

**Place:** **Where are we now** *(state, county, town, street/route number, street name/box number)?* *Give the client 1 point for each correct response.*

**Time:** **Would you tell me the date today** *(year, season, date, day, month)?*

___ Oriented 0
___ Disoriented - Some spheres, some of the time 1
___ Disoriented - Some spheres, all the time 2
___ Disoriented - All spheres, some of the time 3
___ Disoriented - All spheres, all of the time 4
___ Comatose 5

Spheres affected: _____

### Recall/Memory/Judgement

**Recall:** **I am going to say three words, and I want you to repeat them after I am done** (House, Bus, Dog). ✪ Ask the client to repeat them. *Give the client 1 point for each correct response on the first trial.* ✪ Repeat up to 6 trials until client can name all 3 words. Tell the client to hold them in his mind because you will ask him again in a minute or so what they are.

**Attention/ Concentration:** *Spell the word "WORLD". Then ask the client to spell it backwards. Give 1 point for each correctly placed letter (DLROW).*

**Short-Term:** ✪ Ask the client to recall the 3 words he was to remember.

**Long-Term:** **When were you born** (What is your date of birth)?

**Judgement:** **If you needed help at night, what would you do?**

| No 0 | Yes 1 | |
|---|---|---|
| ___ | ___ | Short -Term Memory Loss? |
| ___ | ___ | Long-Term Memory Loss? |
| ___ | ___ | Judgement Problem? |

*Optional:* **MMSE Score**

_____ (5)

_____ (5)

_____ (3)

_____ (5)

**Total:** _____

**Note:** Score of 14 or below implies cognitive impairment

## Behavior Pattern

**Does the client ever wander without purpose** (trespass, get lost, go into traffic, etc.) **or become agitated and abusive?**

___ Appropriate 0
___ Wandering/Passive - Less than weekly 1
___ Wandering/Passive - Weekly or more 2
___ Abusive/Aggressive/Disruptive - Less than weekly 3
___ Abusive/Aggressive/Disruptive - Weekly or more 4
___ Comatose 5

Type of inappropriate behavior: _____ Source of Information: _____

## Life Stressors

**Are there any stressful events that currently affect your life, such as . . . ?**

| No 0 | Yes 1 | | No 0 | Yes 1 | | No 0 | Yes 1 | |
|---|---|---|---|---|---|---|---|---|
| ___ | ___ | Change in work/employment | ___ | ___ | Financial problems | ___ | ___ | Victim of a crime |
| ___ | ___ | Death of someone close | ___ | ___ | Major illness - family/friend | ___ | ___ | Failing health |
| ___ | ___ | Family conflict | ___ | ___ | Recent move/relocation | ___ | ___ | Other: _____ |

CLIENT NAME: Client SSN: - -

## Emotional Status

| In the past month, how often did you . . . ? | Rarely/ Never 0 | Some of the Time 1 | Often 2 | Most of the Time 3 | Unable to Assess 9 |
|---|---|---|---|---|---|
| Feel anxious or worry constantly about things? | | | | | |
| Feel irritable, have crying spells or get upset over little things? | | | | | |
| Feel alone and that you didn't have anyone to talk to? | | | | | |
| Feel like you didn't want to be around other people? | | | | | |
| Feel afraid that something bad was going to happen to you and/or feel that others were trying to take things from you or trying to harm you? | | | | | |
| Feel sad or hopeless? | | | | | |
| Feel that life is not worth living . . . or think of taking your life? | | | | | |
| See or hear things that other people did not see or hear? | | | | | |
| Believe that you have special powers that others do not have? | | | | | |
| Have problems falling or staying asleep? | | | | | |
| Have problems with your appetite . . . that is, eat too much or too little? | | | | | |

**Comments:**

## Social Status

**Are there some things that you do that you especially enjoy?**

**No** 0 **Yes** 1 *Describe*

___ ___ Solitary Activities, _____

___ ___ With Friends/Family, _____

___ ___ With Groups/Clubs, _____

___ ___ Religious Activities, _____

**How often do you talk with your children, family or friends, either during a visit or over the phone?**

**Children**

___ No Children 0
___ Daily 1
___ Weekly 2
___ Monthly 3
___ Less than Monthly 4
___ Never 5

**Other Family**

___ No Other Family 0
___ Daily 1
___ Weekly 2
___ Monthly 3
___ Less than Monthly 4
___ Never 5

**Friends/Neighbors**

___ No Friends/Neighbors 0
___ Daily 1
___ Weekly 2
___ Monthly 3
___ Less than Monthly 4
___ Never 5

**Are you satisfied with how often you see or hear from your children, other family and/or friends?**

___ **No** 0 ___ **Yes** 1

| CLIENT NAME: | Client SSN: - - |
|---|---|

## 5 ASSESSMENT SUMMARY

***Indicators of Adult Abuse and Neglect:*** *While completing the assessment, if you suspect abuse, neglect or exploitation, you are required by Virginia law, Section 63.1 - 55.3 to report this to the local Department of Social Services, Adult Protective Services.*

## Caregiver Assessment

**Does the client have an informal caregiver?**

___ **No** 0 (Skip to Section on Preferences) ___ **Yes** 1

**Where does the caregiver live?**

___ With client 0
___ Separate residence, close proximity 1
___ Separate residence, over 1 hour away 2

**Is the caregiver's help . . .**

___ Adequate to meet the client's needs? 0
___ Not adequate to meet the client's needs? 1

**Has providing care to the client become a burden for the caregiver?**

___ Not at all 0
___ Somewhat 1
___ Very much 2

**Describe any problems with continued caregiving:**

## Preferences

**Client's preferences for receiving needed care:** _____

_____

_____

**Family/Representative's preferences for client's care:** _____

_____

_____

**Physician's comments** (if applicable): _____

_____

_____

| CLIENT NAME: | Client SSN: - - |
|---|---|

## Client Case Summary

## Unmet Needs

| No 0 | Yes 1 | (Check All That Apply) |
|---|---|---|
| ___ | ___ | Finances |
| ___ | ___ | Home/Physical Environment |
| ___ | ___ | ADLS |
| ___ | ___ | IADLS |

| No 0 | Yes 1 | (Check All That Apply) |
|---|---|---|
| ___ | ___ | Assistive Devices/Medical Equipment |
| ___ | ___ | Medical Care/Health |
| ___ | ___ | Nutrition |
| ___ | ___ | Cognitive/Emotional |
| ___ | ___ | Caregiver Support |

## Assessment Completed By:

| Assessor's Name | Signature | Agency/Provider Name | Provider# | Section(s) Completed |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |

*Optional:* Case assigned to: _____ Code #: _____

## PATIENT INFORMATION

**Medicaid ID:**_____ **Provider Name**_____
**Recipient Name:**_____**SSN:**_____**DOB:**_____
**Address:**_____

### I. Provider Section

**Patient Status (Complete Appropriate Blocks)** Report any admission, discharge, and/or change in patient status
Patient admitted to this facility/service on _____(date)

Level of care: ☐ Skilled ☐ Intermediate
Patient discharged or expired on _____(date)

Discharged to: ☐ Home ☐ Hospital ☐ Other Facility ☐ Expired

☐ Case in need of review/DMAS 122 requested

☐ Personal Funds Account balance $_____

☐ Patient's income or deductions have changed

☐ Explain/other:_____

Prepared by Name:_____ Title:_____

Telephone:_____ Date:_____

### II. DSS Section

**Eligibility Information: (Check One)**

☐ Is eligible for full Medicaid services beginning _____(date)

☐ Is ineligible for Medicaid services

☐ Is eligible for QMB Medicaid only

☐ Is ineligible for Medicaid payment of LTC services from_____to_____due to asset transfer.

☐ Is eligible for Medicare premium payment only

☐ Has Medicare Part A insurance

☐ Has other health insurance

### III. Patient Pay Information

| | MMYY | MMYY | MMYY |
|---|---|---|---|
| | _____ | _____ | _____ |
| Patient Pay amount | _____ | _____ | _____ |
| Comments: | | | |

**NOTE:** Medicaid long-term care providers cannot collect more than the Medicaid rate from the patient. Income is used for the cost of care in the month in which it is received, e.g., the SSA check received in January is used toward the cost of care in January.

Worker Name:_____

Agency Name:_____FIPS Code:_____

Telephone:_____ **Date:**_____

**PATIENT INFORMATION**
FORM NUMBER DMAS-122

PURPOSE OF FORM—To allow the local DSS and the nursing facility or Medicaid Community-based Care provider to exchange information regarding:

1. The Medicaid eligibility status of a patient;
2. The amount of income an eligible patient must pay to the provider toward the cost of care;
3. A change in the patient's level of care;
4. Admission or discharge of a patient to an institution or Medicaid CBC services, or death of a patient;
5. Other information known to the provider that might cause a change in the eligibility status or patient pay amounts.

USE OF FORM--Initiated by either the local DSS or the provider of care. The local DSS must complete the form for each nursing facility or CBC waiver patient at the time initial eligibility is determined or when a Medicaid enrolled recipient enters a nursing facility or CBC waiver services. A new form must be prepared by the local DSS whenever there is any change in the patient's circumstances that results in a change in the amount of patient pay of the patient's eligibility status. The local DSS must send an updated form to the provider at least once a year, even if there is no change in patient pay.

The provider must use the form to show admission date, to request a Medicaid eligibility status, Medicaid recipient I.D., and patient pay amount; to notify the local DSS of changes in the patient's circumstances, discharge or death.

NUMBER OF COPIES—Original and one copy for nursing facility patients and original and two copies for CBC patients.

DISTRIBUTION OF COPIES—For nursing facility patients, send the original to the nursing facility and file the copy in the eligibility case folder. For Medicaid CBC patients, refer to section M1470.800 B.2. to determine where the original and any copies of forms are sent.

INSTRUCTIONS FOR PREPARATION OF THE FORM—Complete the heading with the name of the nursing facility or Medicaid CBC provider, the address, the patient's name, social security number, and Medicaid recipient I.D.

Section I is for the provider to complete. Section II must be completed by the local DSS. Fill in the appropriate spaces.

Eligibility information

1. Check the first block on an initial form sent in conjunction with the approval of a new Medicaid application, showing the effective date of coverage.
2. Check the second block if the individual is ineligible for payment of **all** Medicaid services.
3. Check the third block if the individual is eligible as QMB only-(not dually eligible).
4. Check the fourth block if ineligible for Medicaid payment due to transfer of assets. Dates of disqualification must be listed on the form. Send copy to DMAS.
5. Check the fifth block if eligible for Medicare premium payment only.
6. Check the sixth block if the individual has Medicare Part A insurance.
7. Check the last block if the individual has other health insurance.

Patient Pay Information

Enter the month and year in which patient pay amount is effective. Enter the patient pay amount under the appropriate month and year.

**PRE-ADMISSION SCREENING CRITERIA FOR NURSING HOME CARE**

Functional dependency alone is not sufficient to demonstrate the need for nursing home care or placement.

Except as provided for individuals who require the daily direct services of a licensed nurse that cannot be managed on an outpatient basis, an individual may only be considered to meet the nursing home criteria when both the functional capacity of the individual and his or her medical or nursing needs meet the following requirements. Even when an individual meets nursing home criteria, placement in a noninstitutional setting shall be evaluated before actual nursing home placement is considered.

Functional capacity

Functional capacity must be documented on the DMAS-95 assessment instrument, completed in a manner consistent with the definitions of activities of daily living and directions provided by DMAS for the rating of those activities. Individuals may be considered to meet the functional capacity requirements for nursing home care when one of the following describes their functional capacity:

1. Rated dependent in two to four of the Activities of Daily Living, and also rated semi-dependent or dependent in Behavior Pattern and Orientation, and semi-dependent in Joint Motion or semi-dependent in Medication Administration;

2. Rated dependent in five to seven of the Activities of Daily Living and also rated dependent in Mobility; or

3. Rated semi-dependent in two to seven of the Activities of Daily Living and also rated dependent in Mobility and Behavior Pattern and Orientation.

The rating of functional dependencies on the pre-admission screening assessment instrument must be based on the individual's ability to function in a community environment, not including any institutionally induced dependence. The following abbreviations shall mean:

I = independent
d = semi-dependent
D = dependent

MH = mechanical help
HH = human help

| (1) | Bathing | | (2) | Dressing | |
|---|---|---|---|---|---|
| (a) | Without help | **(I)** | (a) | Without help | **(I)** |
| (b) | MH only | **(d)** | (b) | MH only | **(d)** |
| (c) | HH only | **(D)** | (c) | HH only | **(D)** |
| (d) | MH and HH | **(D)** | (d) | MH and HH | **(D)** |
| (e) | Is bathed | **(D)** | (e) | Is dressed | **(D)** |
| | | | (f) | Is not dressed | **(D)** |

| (3) | Toileting | | (4) | Transferring | |
|---|---|---|---|---|---|
| (a) | Without help day or night | **(I)** | (a) | Without help | **(I) (d)** |
| (b) | MH only | **(d)** | (b) | MH only | |
| (c) | HH only | **(D)** | (c) | HH only | **(D)** |
| (d) | MH and HH | **(D)** | (d) | MH and HH | **(D)** |
| (e) | Performed by others | **(D)** | (e) | Performed by others | **(D)** |
| | | | (f) | Is not preformed | **(D)** |

| (5) | Bowel Function | | (6) | Bladder Function | |
|---|---|---|---|---|---|
| (a) | Continent | **(I)** | (a) | Continent | **(I)** |
| (b) | Incontinent less than weekly | **(d)** | (b) | Incontinent less than weekly | **(d)** |
| (c) | External/In-dwelling device/ Ostomy self-care | **(d)** | (c) | External device self care | **(d)** |
| (d) | Incontinent weekly or more | **(D)** | (d) | Indwelling catheter self care | **(d)** |
| (e) | Ostomy not self-care | **(D)** | (e) | Ostomy self care | **(d)** |
| | | | (f) | Incontinent weekly or more | **(D)** |
| | | | (g) | External device, not self care | **(D)** |
| | | | (h) | Indwelling catheter, not self-care | **(D)** |
| | | | (i) | Ostomy not self-care | **(D)** |

| **(7) Eating/Feeding** | | | **(8) Behavior Pattern and Orientation** | | |
|---|---|---|---|---|---|
| (a) | Without help | **(I)** | (a) | Appropriate or Wandering/ Passive less than weekly + Oriented | **(I)** |
| (b) | MH only | **(d)** | (b) | Appropriate or Wandering/Passive < weekly + Disoriented Some Spheres | **(I)** |
| (c) | HH only | **(D)** | (c) | Wandering/Passive Weekly or more + Oriented | **(I)** |
| (d) | MH and HH | **(D)** | (d) | Appropriate or Wandering/Passive < weekly + Disoriented All Spheres | **(d)** |
| (e) | Spoon fed | **(D)** | (e) | Wandering/Passive Weekly some or more + Disoriented All Spheres | **(d)** |
| (f) | Syringe or tube fed | **(D)** | (f) | Abusive/Aggressive/ Disruptive< weekly + Oriented or Disoriented | **(d)** |
| (g) | Fed by IV or clysis | **(D)** | (g) | Abusive/Aggressive/ Disruptive weekly or more + Oriented | **(d)** |
| | | | (h) | Abusive/Aggressive/ Disruptive + Disoriented All Spheres | **(D)** |

| **(9) Joint Motion (NF)** | | | **(10) Mobility** | | |
|---|---|---|---|---|---|
| (a) | Within normal limits | **(I)** | (a) | Goes outside without help | **(I)** |
| (b) | Limited motion | **(d)** | (b) | Goes outside MH only | **(d)** |
| (c) | Instability corrected | **(I)** | (c) | Goes outside HH only | **(D)** |
| (d) | Instability uncorrected | **(D)** | (d) | Goes outside MH and HH | **(D)** |
| (e) | Immobility | **(D)** | (e) | Confined moves about | **(D)** |
| | | | (f) | Confined does not move about | **(D)** |

| **(11) Medication Administration (NF)** | | | **(12) Medication Administration (ACR)** | | |
|---|---|---|---|---|---|
| (a) | No medications | **(I)** | (a) | Without assistance | **(I)** |
| (b) | Self-administered, monitored < weekly | **(I)** | (b) | Administered, | **(D)** |
| (c) | By lay persons administered/ monitored | **(D)** | (c) | monitored by lay person Administered, monitored by professional staff | **(D)** |
| (d) | By licensed/ professional nurse administered/ monitored | **(D)** | | | |

| (13) Behavior Pattern | | | (14) Instrumental Activities of Daily Living (ACR) | | |
|---|---|---|---|---|---|
| (a) | Appropriate | **(I)** | (a) | Meal Preparation | |
| (b) | Wandering/ passive less than weekly | **(I)** | | (1) No help needed<br>(2) Needs help | **(D)** |
| (c) | Wandering/ passive weekly or more | **(d)** | (b) | Housekeeping<br>(1) No help needed<br>(2) Needs help | **(D)** |
| (d) | Abusive/ aggressive/ disruptive less than weekly | **(D)** | (c) | Laundry<br>(1) No help needed<br>(2) Needs help | **(D)** |
| (e) | Abusive/ aggressive/ disruptive weekly or more | **(D)** | (d) | Money Management<br>(1) No help needed<br>(2) Needs help | **(D)** |

Medical and Nursing Needs

An individual with medical or nursing needs is an individual whose health needs require medical or nursing supervision or care above the level which could be provided through assistance with Activities of Daily Living, Medication Administration, and general supervision and is not primarily for the care and treatment of mental diseases. Medical or nursing supervision or care beyond this level is required when any one of the following describes the individual's need for medical or nursing supervision:

1. The individual's medical condition requires observation and assessment to assure evaluation of the person's need for modification of treatment or additional medical procedures to prevent destabilization, and the person has demonstrated an inability to self-observe or evaluate the need to contact skilled medical professionals; or

2. Due to the complexity created by the person's multiple, interrelated medical conditions, the potential for the individual's medical instability is high or medical instability exists; or

3. The individual requires at least one ongoing medical or nursing service. The following is a non-exclusive list of medical or nursing services which may, but need not necessarily, indicate a need for medical or nursing supervision or care:

   (a) Application of aseptic dressings;
   (b) Routine catheter care;

   (c) Respiratory therapy;

   (d) Supervision for adequate nutrition and hydration for individuals who show clinical evidence of malnourishment or dehydration or have a recent history of weight loss

or inadequate hydration which, if not supervised, would be expected to result in malnourishment or dehydration;

(e) Therapeutic exercise and positioning;

(f) Routine care of colostomy or ileostomy or management of neurogenic bowel and bladder;

(e) Use of physical (e.g., side rails, poseys, locked wards) or chemical restraints;

(f) Routine skin care to prevent pressure ulcers for individuals who are immobile;

(g) Care of small uncomplicated pressure ulcers and local skin rashes;

(h) Management of those with sensory, metabolic, or circulatory impairment with demonstrated clinical evidence of medical instability;

(g) Chemotherapy;

(h) Radiation;

(i) Dialysis;

(j) Suctioning;

(i) Tracheostomy care;

(j) Infusion therapy; and

(k) Oxygen.

Even when an individual meets nursing home criteria, provision of services in a noninstitutional setting shall be considered before nursing home placement is sought.

Summary of Pre-Admission Screening Criteria for Nursing Home Care

An individual shall be determined to meet the nursing home criteria when:

1. The individual has both limited functional capacity and requires medical or nursing management according to the requirements of the Pre-Admission Screening Criteria for Nursing Home Care; or

2. The individual is rated dependent in some functional limitations, but does not meet the functional capacity requirements, and the individual requires the daily direct services or supervision of a licensed nurse that cannot be managed on an outpatient basis (e.g., clinic, physician visits, or home health services).

An individual shall not be determined to meet nursing home criteria when one of the following specific care needs solely describes his or her condition:

1. An individual who requires minimal assistance with activities of daily living, including those persons whose only need in all areas of functional capacity is for prompting to

complete the activity;

2. An individual who independently uses mechanical devices such as a wheelchair, walker, crutch, or cane;

3. An individual who requires limited diets such as a mechanically altered, low salt, low residue, diabetic, reducing, and other restrictive diets;

4. An individual who requires medications that can be independently self-administered or administered by the caregiver;

5. An individual who requires protection to prevent him or her from obtaining alcohol or drugs or to address a social or environmental problem;

6. An individual who requires minimal staff observation or assistance for confusion, memory impairment, or poor judgment; or

7. An individual whose primary need is for behavioral management which can be provided in a community-based setting;